



Jawzjan Province, Afghanistan CS-19 First Annual Report

*Provincial Strengthening in Northern Afghanistan:
Capacity Building and Innovation to Support the Basic Package of Health Services and Sustainably
Improve Access, Quality and Use of Essential MCH Services throughout Jawzjan Province*

Standard Child Survival and Health Grant
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ACRONYMS AND TERMS

ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival (USAID-supported Project)
BC	Behavior Change
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin/Tuberculosis Vaccine
BHC	Basic Health Center
BPHS	Basic Package of Health Service
CCM	Community Case Management
CDD	Control of Diarrheal Diseases
CDQ	Community Defined Quality
CFHE	Child Focused Health Education
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DD Ops.	Deputy Director of Operations
DIP	Detailed Implementation Plan
DMT	District Management Team
DPT	Diphtheria-Pertussis-Tetanus Vaccine
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FOD	Field Office Director
FP	Family Planning
GM	Growth Monitoring
GMP	Growth Monitoring and Promotion
HF	Health Facility
HIS	Health Information System
HMIS	Health Management Information System
HP	Health Post
IEC	Information, Education, and Communication
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge, Practices, and Coverage (survey)
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNC	Maternal and Newborn Care (CS-18 intervention)
MOH	Ministry of Health
MSH	Management Sciences for Health
NID	National Immunization Day
OPD	Outpatient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PDQ	Partner Defined Quality

PHCC	Provincial Health Coordination Committee
PHO	Provincial Health Office (of the MOH)
PMT	Provincial Management Team
PNC	Prenatal Care
PPO	Provincial Polio Officer (WHO title for EPI Officer)
PRA	Participatory Rapid Appraisal
PVO	Private Voluntary Organization
REACH	Rural Expansion of Afghanistan's Community-based Healthcare Program
RH	Reproductive Health
RHA	Regional Health Advisor
SC	Save the Children(US) Federation, Inc.
SM	Safe Motherhood
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training-of-Trainers
TT	Tetanus Toxoid Vaccine
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAZ	Weight-for-Age Z-score
WHO	World Health Organization
WRA	Women of Reproductive Age

A. PROGRAM ACCOMPLISHMENTS

1. Orientation of MOH, CS-19 and REACH Staff:

Between October and November 2003, Save the Children's CS-19 coordinator and the Asia Regional Health Advisor (RHA) conducted a one-day orientation session with the key MOH staff to a) note the official start date of the CS-19 project and b) review key CS-19 interventions, approaches and target areas.

2. Completion of Baseline Studies

In November 2003, the coordinator and Asia RHA planned baseline studies as outlined in the CS-19 proposal. Five studies were planned, with three completed by January 2004 and two completed by August 2004 as follows:

- Two Integrated Health Facility Assessments, using USAID/BASICS tools;
- One Knowledge, Practice and Coverage (KPC) survey;
- 30 focus group discussions (FGD) to explore health-seeking behaviors, barriers and solutions; and
- A Gap Analysis to assess gaps in the Safe Motherhood (SM) service provision.

2.1. Integrated Health Facility Assessments (December 2003):

Integrated Health Facility Assessments (IHFA) were conducted in both the Andkhoy cluster of districts and in Jawzjan Province covering 18 health facilities, including 11 Basic Health Centers (BHC), two outpatient departments (OPD) of district hospitals, one Comprehensive Health Center (CHC), two Maternal-Child Health (MCH) clinics, one health post (HP), and the pediatric department of the provincial hospital. The visits to these facilities were unannounced in order to provide as accurate a picture as possible of the provision of regular child health care services. Four USAID/BASICS IFHA questionnaires [1. Observation Checklist–Sick Child, 2. Exit Interview–Sick Child, 3. Health Care Worker Interview, and 4. Equipment and Supplies Checklist] were used to evaluate:

- The assessment, diagnosis, and treatment of children with diarrhea, fever and malaria, and acute respiratory infections (ARI);
- The screening and vaccination of women and children against common vaccine-preventable diseases;
- How caretakers provide home treatment for their children;
- How health workers educate caretakers about preventive and curative care;
- The quality of health worker training and supervision; and
- Equipment, supplies and record keeping in health facilities.

The assessment team included four Save the Children (SC), Integrated Management of Childhood Illness (IMCI) trained doctors, four MOH doctors and seven MOH nurses who received a five-day training in December 2003. This training included a two-day field test by the RHA and other senior SC health staff. Doctors were responsible for implementing observation checklists, health worker interviews, and supply/equipment checklists. The nurses conducted the caregiver exit interviews.

The assessment team interviewed 17 physicians and one nurse using the Health Worker Interview questionnaire, conducted an inventory of the supplies and equipment in the facilities, and observed

and validated 155 examinations (109 in Jawzjan Province and 46 in the Andkhoy cluster) and diagnoses of children under the age of five, and interviewed the children's caretakers.

Four people were trained in EPI INFO data entry from December 5-11, 2003 and data were sent to an outside consultant for cleaning and analysis. Findings were reviewed and discussed in the field in preparation for the detailed implementation plan (DIP) development.

Challenges:

In addition to the limited number of patients and caretakers available for observation and interviews at two of the facilities, the weather was cold and rainy and long distances to some facilities delayed data entry.

2.2. Knowledge, Practice and Coverage (KPC) Survey (November 2003)

A 30-cluster KPC survey was conducted in Jawzjan Province using a systematic random sampling technique. A consultant adapted the KPC questionnaire from the KPC 2000+ modules, and the questionnaire was translated into Dari. The survey team included 16 local female schoolteachers who were trained and supervised by senior SC and MOH staff with technical assistance, guidance and oversight provided by the RHA. A four-day training, followed by a two-day field-test and further training, prepared the team for six days of surveying.

A total of 300 mothers with a child between 0-23 months were interviewed for baseline information on the following indicators:

- % increase in mothers of children <2 receiving two or more tetanus toxoid (TT) doses before birth of youngest child;
- % of 12-23 month olds fully immunized (against 6 diseases) by age 12 months;
- % of 12-23 month olds who received vitamin A in last 6 months;
- % increase in ill children receiving increased fluids and continued feeding during illness in past 2 weeks;
- % increase in mothers reporting hand washing before food preparation and child feeding, and after defecation and child defecation;
- % increase in % of children <2 whose births were attended by skilled health personnel;
- % increase in mothers with one or more postpartum check-up;
- % increase in non-pregnant mothers who desire no more children in next two years, or are unsure, who are using a modern method of child spacing;
- % of mothers who know two or more signs of child illness needing treatment; and
- % increase in mothers with knowledge of at least two maternal danger signs during the postpartum period.

Three data entry staff were trained in EPI-INFO version 6, and data entry took seven days. Data were cleaned and analyzed by a consultant and findings were shared with MOH and SC staff for discussion. The final reports are included in the DIP.

2.3. Focus Group Discussions (January and February 2004)

One of the recommendations from the KPC findings suggested conducting focus group discussions (FGD) to further understand barriers to care seeking, particularly for immunization and safe motherhood services; to learn about birth preparedness/planning practices; and to understand why the use of family planning (FP) is so low and what could be done to increase access to FP services. Additionally, FGDs were used to identify local terms and practices used to describe childhood illness, home care, and care-seeking behaviors for sick children.

Three checklists were developed to target different community members. A two-day refresher training was offered to 10 teachers and healthcare workers in the Andkhoy cluster (six female and four male) and six female schoolteachers and nurses, and four male health workers were trained on participatory rapid appraisal techniques for three days in Jawzjan Province.

A total of 541 community members participated in 52 FGDs over four days in Andkhoy and Jawzjan. Groups included mothers with children under six months old, mothers and fathers with children 6-24 months old, and adult women and men talking about family planning. The final report from the FGD is included in the Annex section of this document.

2.4. Gap Analysis for Maternal and Newborn Care (August 2004)

The three levels in the Household to Hospital Continuum of Care (HHCC) are the following: the household; the periphery and its facilities, including community health centers, basic health centers, MCH units, private maternity homes, and all other facilities/services up to the district hospital or district referral facility; and the district hospital or referral facility.

Based on the recommendations of SC's Office of Health's RH advisor, the Gap Analysis tool looked at services that should or could be available (per protocol and evidence) at all these three levels and identified existing gaps that contribute to maternal death and disability. A colleague from SC's Pakistan health team completed the Gap Analysis between August 8 - 18, 2004, and a nalysis results were used to make recommendations to improve existing services. The final report from the Gap Analysis is included in Annex 1 of this document.

3. Completion of CS-19 staff recruitment

The project is now fully staffed with the addition of the following key staff:

- Four senior officers for EPI, MNC, ARI/CDD and BCC based in Shiberghan City (in Jawzjan);
- Two health officers based in Andkhoy; and
- 10 MCH promoters for 10 Jawzjan health facilities based in the relevant districts.

All new staff received an orientation to CS-19, Afghanistan's Basic Package of Health Services (BPHS) and the REACH initiative which SC is implementing in coordination with CS-19.

4. Support to MOH staff working in six rural areas of Shiberghan district

Through CS-19, SC supports these MOH facilities by providing:

- a. Trainings to the MOH health staff in these six remote villages in the following areas:
 - Child immunization: BCG, OPV, DPT and measles
 - Safe motherhood services: antenatal care, TT vaccines, iron supplementation, birth planning/preparedness education
 - Treating children under five years with ARI, diarrhea and fever
 - Health information/health education;
- b. Rented vehicles to transport the health teams to these six villages;
- c. Joint supervision and support trips, together with key MOH staff;
- d. Assistance with analysis and compilation of health information services (HIS) data, and feedback to the health teams throughout the district in collaboration with MOH staff;
- e. Technical assistance support for teams during national immunization days (NID), CDD and ARI campaigns; and
- f. Community mobilization activities.

The MOH provides essential drugs, vaccines and EPI supplies, and all staff that serve these six locations (one doctor, one female nurse, one midwife, one vaccinator [two during outreach activities] and one health educator.) SC will continue to provide technical support to these six MOH teams throughout the CS-19 Project. However, SC will discontinue transportation of MOH staff to these facilities when permanent clinics are established by the MOH (with help from other NGOs) in these six locations, and the MOH staff is permanently based there. This is expected to take place prior to the conclusion of CS-19.

5. Joint monitoring and supervision with MOH of EPI and CDD activities

Joint monitoring and supervision takes place weekly in Andkhoy, Qaramqol, Khancharbagh, and Qurghan Districts in Faryab Province and Qarqin, Khamyab, and Khwaja du Koh to strengthen EPI and CDD interventions.

6. Coordination with the MOH and other NGOs

The CS-19 coordinator serves as the Secretary for the MOH Provincial Health Coordinating Committee (PHCC.) Monthly meetings of all NGOs and providers occur in Jawzjan of all NGOs and providers to discuss health issues, activities and plans throughout the province. Both Save the Children (US) and Save the Children (UK) participate in these meetings.

Save the Children (US) is coordinating training efforts with Save the Children (UK) and other NGOs, to avoid duplication of effort and standardization of messages and activities. Additionally, all SC staff implementing the BPHS is included in any applicable CS-19 trainings and vice versa. Further, CS-19 staff meets with MOH, WHO and UNICEF staff before conducting all trainings to ensure that information is in accordance with national policy and up-to-date, and coordinates training materials to comply with national standards.

SC's CS-19 and REACH staff (implementing the BPHS) worked closely together to select Community Health Workers in the REACH project implementation districts. Staff of both projects collaborate and coordinate efforts on a daily basis, including information exchange and joint field visits. The CS-19 Senior Health Officer for MNC was instrumental in identifying and selecting

appropriate students for the new REACH-funded Community Midwife Education Program based in Shiberghan.

7. Reporting

Quarterly reports are submitted to the MOH Provincial Health Director, and monthly reports and workplans are sent to Management Sciences for Health (MSH) in Kabul to ensure comprehensive reporting on all USAID-funded SC health projects. Sample reports are included in Annex 3 of this document.

8. Progress made as per workplan

EPI (20%)			
Indicator 2	% of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before first birthday (by card)		
Indicator 3	% of infants who received DPT3		
Indicator 4	% of 12-23 month olds who received the measles vaccine (by recall)		
Activities	Year One Benchmarks	Benchmark Achieved	Comments
EPI Management training for PHO (including sections on HMIS, M&E, keeping registers/log books, and community mobilization)	To be completed by Year 1 Quarter 4	Achieved	The CS-19 coordinator, CS-19 EPI officer and MOH EPI officer conducted this training for an MOH provincial EPI manager, 2 cold chain technicians, 5 doctors from CS-19 supported clinics, 4 Save the Children/UK training officers and one Save the Children/USA's REACH training officer. Trainers used MOH/WHO/UNICEF-accepted guidelines. Trained MOH staff will participate in community mobilization activities, and training and supervision of vaccinators.
Immunization coverage data collected to support PHO in HMIS, detection of priorities and giving feedback.	Planned for Year 2 Quarter 1	Achieved in District 7	CS-19 EPI officer, Andkhoy's 2 CS-19 officers and the MOH EPI Manager collected and reviewed EPI reports from clinics. They then planned an HMIS Training-of-trainers for clinic supervisors.
Develop IEC/health education materials	To be completed by Year 1 Quarter 4	Achieved	<ul style="list-style-type: none"> NID supervisors and volunteers were trained using WHO NID education materials Staff developed an EPI pictorial story for CFHE.
On-the-spot technical assistance to PHO staff	To be completed by Year 1 Quarter 4	Achieved	The CS-19 EPI officer and MOH EPI Manager carried out 15 visits to 7 health facilities to provide on the job technical trainings.

Microplans developed for poor access areas	Planned for Year 2 First Quarter		CS-19 EPI and BCC officers attended a WHO-organized regional EPI microplanning workshop (10-11 Aug 04), after which the CS-19 officers led the training at the provincial level for MOH NID coordinators and supervisors.
Support the MOH in NIDs	Year 2 Quarter 1	In progress	CS-19 EPI and BCC officers received a TOT training by WHO on EPI NIDs and then trained NID coordinators, supervisors and volunteers. In consultation with MOH/UNICEF/WHO, the CS-19 coordinator has scheduled NID trainings and implementation monitoring for all target districts.
CDD (15%)			
Indicator 5	% of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness		
Indicator 6	% of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness		
Indicator 7	% of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated		
Indicator 14	% mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment		
Indicator 16	% of MOH facilities with 1 or more stock-out of ORS or essential drugs last month		
Indicator 17	CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented		
Indicator 18	% of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home		
Indicator 19	% of caretakers of <5s know at least 2 aspects of home care		
Indicator 20	% of caretakers of <5s know at least 2 signs of when to return if child gets worse		
Indicator 21	% of severely ill <5s classified correctly in MOH facilities		
Indicator 24	% of <5 diarrhea cases treated correctly in MOH facilities		
Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
CDD case management training	Year 1 Quarter 4	Achieved	Using MOH/WHO/UNICEF-provided guidelines, CS-19 ARI/CDD officer and MOH pediatrician led a 3-day CDD case management training for 10 MOH doctors including those from CS-19-supported clinics, 3 MCH promoters and 6 midwives.
Development and implementation of checklists	Year 2 Quarter 1	Achieved	WHO CDD checklist adapted; CS-19 ARI/CDD officer and MOH ARI/CDD officer made 8 visits to REACH-supported health facilities to supervise use of the CDD checklist.

MCH promoters work with CHWs	Year 1 Quarter 4	On-going	CS-19 MNC officer helped REACH officers select CHWs. CS-19 coordinator made a schedule for MCH promoters to supervise Health Posts regularly (at least 2x/month).
Development of CDD training modules	Year 2 Quarter 1	Ongoing	Adapted WHO CDD training module to incorporate treatment with zinc and new ORS formula, which CS-19 coordinator shared with WHO Officer in Charge, MOH ARI/CDD officer and CS-19 ARI/CDD officer.
On-the-spot technical support to PHO technical officers	Year 1 Quarter 4	On-going	The CS-19 ARI/CDD officer and MOH ARI/CDD officer made 7 visits to 7 REACH –supported health facilities to review ORT corners and health workers case management and counseling skills, and to conduct on-the-job training.
ARI (20%)			
Indicator 5	% of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness		
Indicator 6	% of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness		
Indicator 8	% of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source		
Indicator 14	% mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment		
Indicator 16	% of MOH facilities with 1 or more stock-out of essential drugs last month		
Indicator 17	CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented		
Indicator 18	% of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home		
Indicator 19	% of caretakers of <5s know at least 2 aspects of home care		
Indicator 20	% of caretakers of <5s know at least 2 signs of when to return if child gets worse		
Indicator 21	% of severely ill <5s classified correctly in MOH facilities		
Indicator 23	% of <5 ARI cases treated correctly in MOH facilities		
Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
ARI/CDD case management training	Year 1 Quarter 4	Not achieved	Planned ARI training for November (seasonal training)
Develop and implement checklists	Year 2 Quarter 1	Achieved	BASICS tools (observation checklists and caregiver exit interviews) adapted and in use in Andkhoy cluster and in Shiberghan; will use checklists in other Jawzjan districts after October ARI training; will train MOH ARI/CDD officer and REACH training officers to use checklists during supervisions.
MCH promoters work with CHWs	Year 1 Quarter 4	Achieved	MCH promoters helped identify CHWs; and have started establishing relationships.

Development of ARI training modules	Year 2 Quarter 1	Achieved	CS-19 ARI/CDD officer, with Mazar-i Sharif SC/US senior health officers adapted WHO ARI training module based on IMCI algorithms.
On-the-spot technical support to PHO technical officers	Year 1 Quarter 4	Achieved	The CS-19 ARI/CDD officer and MOH ARI/CDD officer made 7 visits to 7 health facilities supported by REACH.
Adapt ARI IEC materials	No benchmarks	Achieved	CS-19 coordinator and ARI/CDD officer reviewed and adapted ARI IEC materials from another SC health project.

Nutrition (15%)

Indicator 11 % of infants 0-5 months who were fed breast milk only in the last 24 hours.

Indicator 12 % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.

Activities	Year One Benchmarks	Benchmark Achieved	Comments
Development of IEC materials on nutrition and growth	Year 1 Quarter 4	Achieved	Using WHO, MOH and SC/USA materials, CS-19 BC officer and MOH nutrition officer prepared a Dari iodine and iron module; now developing Dari IEC tools for Vitamin A and iodine.
GMP technical support	Year 2 Quarter 2	Achieved in Andkhoy cluster	CS-19 MNC officer gave GMP refresher course to MOH MCH officer, 10 CS-19 MCH promoters, 4 Save the Children/UK REACH officers and 11 auxiliary midwives.
PD/Hearth training	Year 2 Quarter 2	No benchmarks for Year 1	PD Hearth training module outlined and PDI training module developed; PDI tools are being adapted for the district.
Community mobilization technical support	Year 2 Quarter 1	Achieved	NID community mobilization carried out, including Vitamin A messages.

MNC (30%)			
Indicator 9	% of children aged 0-23 months whose delivery was attended by skilled health personnel		
Indicator 10	% of mothers who had at least one postpartum check-up		
Indicator 11	% of infants aged 0-5 months who were fed breast milk only in the last 24 hours		
Indicator 12	% of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours		
Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
MNC Training	Year 1 Quarter 4	Achieved	CS-19 MNC and MOH MCH officers held MNC training for 2 MOH doctors, a REACH officer, 2 Save the Children/UK REACH training officers, 10 MCH promoters, 11 midwives and Andkhoy's 2 health officers in 2 sessions (9 days each). Training included theoretical/practical aspects; trainers used MOH/WHO/UNICEF-accepted guidelines.
Community Midwife Training	Year 1 Quarter 4	Not achieved	SC is implementing an 18-month USAID REACH-funded midwifery education program. CS-19 MNC Officer and other CS-19 staff helped identify candidates; other staff administered the entrance exam. Year 3 CS-19 funds will be used to support refresher courses/trainings.
Development of BCC messages	Year 2 Quarter 1	Achieved in Andkhoy	SC's existing MNC BC materials/messages are in use in the Andkhoy cluster.
Collaboration with REACH on recruiting female health workers	Year 1 Quarter 3 & 4	Achieved	CS-19 staff worked with REACH staff to identify CHWs in REACH areas.
Technical support on community mobilization	Year 2 Quarter 1	On-going	CS-19 MCH promoters and officers and MOH REACH staff have held 7 meetings with male and female Community Health Councils. PDQ implementation set for Y2Q1.
Development of supervisory checklists and quarterly monitoring	Year 1 Quarters 3 and 4	Achieved	Advisors helped CS-19 staff develop MNC supervisory checklists; 3 monitoring visits carried out in Q3; 2 in Q4.

All interventions			
Indicator 22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality.		
Indicator 25	% of mothers receiving general information or advice on health or nutrition from a member of the informal community network.		
Indicator 26	% of CDQ Quality Improvement Committees including at least one female participant.		
Activities	Year One Benchmarks	Benchmark Achieved	Comments
Attend PHCC monthly meetings	Year 1 Quarters 3 and 4	Achieved	CS-19 coordinator and program manager attended 11 PHCC meetings; CS-19 coordinator is the PHCC executive secretary.
Reporting of baselines to NGOs and MOH	Year 1 Quarters 3 and 4	Achieved	Shared baselines (KPC surveys and Gap Analysis) with MOH and Save the Children/UK
Completion of Gap Analysis	Year 1 Quarter 4	Achieved	Completed; report attached
Completion of qualitative reports	Year 1 Quarter 4	Achieved	Completed a focus group discussion report; attached as an annex to KPC surveys.
Development of CDQ implementation with REACH	Year 1 Quarter 4	Achieved	A discussion during the DIP process on USAID/Afghanistan's suggestion that CS19 coordinate CDQ methodology with a similar quality-improvement methodology developed by MSH (FFSDP). Agreed that Save the Children pilot CDQ and REACH pilot FFSDP and agencies share results.
CS-19 intervention task forces monitoring meetings	Year 1 Quarter 4	Achieved	During CS-19 DIP meetings and KPC results feedback sessions, 4 meetings were held with ARI, CDD, MNC, EPI and nutrition task forces.
Transportation provided for health staff at 6 MOH clinics	Year 1 Quarter 3&4	Achieved	Supplied vehicles for staff providing health services in 6 Shiberghan villages.

B. FACTORS THAT HAVE IMPEDED PROGRESS TOWARDS ACHIEVEMENT

Difficulty in hiring qualified staff, particularly qualified female staff, has been a challenge. Additionally, CS-19 activities are designed to coordinate with REACH activities, and late start-up of planned REACH activities delayed some of CS-19 training plans in order to support joint coordination. Communications limitations in rural Afghanistan sometimes precluded access to information and/or delayed assistance in some extenuating situations. However, in spite of these difficulties, CS-19 activities are progressing in accordance with the workplan.

C. TECHNICAL ASSISTANCE

Technical assistance is a large part of the overall CS-19 workplan, and will involve continued training and on-the-spot assistance to CS-19 staff as well as MOH staff. Technical assistance in the first year is included in the workplan in Section A (Accomplishments). Additionally, the RHA provided overall support and guidance for baseline studies, including KPC surveys, focus group discussions and the Gap Analysis, with SC's Pakistan Field Office providing additional technical assistance to complete the Gap Analysis. The CS Specialist from SC Headquarters in Westport, CT provided technical assistance during the DIP development, and provides additional assistance as needed.

D. SUBSTANTIAL CHANGES IN THE PROGRAM DESCRIPTION

There have been no substantial changes from the program description/DIP that will require a modification to the Cooperative Agreement.

E. RESPONSE TO RECOMMENDATIONS MADE IN THE DIP REVIEW

Our reviewers were Helga Morrow, Jennifer Winestock, Jim Ricca and Sanjay Patel. Responses to recommendations and questions from all three are included below by category:

1. CS-19 versus REACH

There is a danger to linking REACH (3 year program) with CS-19 (5 year program.)

SC should have plans in place to ensure that there will not be a gap in community and district level support if REACH is not funded for a second cycle. Will CSHGP activity shift coverage to meet the gap?

Response: The donor community will not likely back away from support of Afghanistan's new health policy, and the BPHS is expected to be re-funded (regardless of who the service provider is, e.g., the MOH or an NGO) within the CS19 project life. However, an essential element of CS19 activities is supporting, training and helping to supervise MOH staff in providing the essential package of services, which builds capacity that will be sustained after REACH and CS19 funding has ended.

2. Training and supervision

Very little or no emphasis is placed on doing needs assessments and developing training objectives.

SC should develop a system's based approach to supervision that includes mentoring, coaching, information sharing...an activity that merits more than the use of checklists.

Response: In coordination with the MOH, the CS-19 coordinator and other technical staff have been involved in the development of training materials in the CS-19 interventions, as well as the development of pre- and post-tests, and along with REACH staff, have developed training needs assessments. If not clearly stated in the DIP, the training plans involve much more than checklists.

3. Family planning as an intervention

I would encourage SC to include a more strategic approach to promote child spacing given the impact it could have on the high maternal mortality rate. Why wait until mid-project to begin?

Response: CS-19 has scheduled child spacing intervention to begin mid-project in order to align with REACH activities around this intervention. This is not a first tier-activity for REACH, and systems are not yet in place in many facilities to support an earlier start-up.

4. Baseline data informing activities

Baseline data and end of project targets are very different for Andkhoy Cluster and Jawzjan Province. The project should elaborate more on what the difference will be between the two areas in terms of focus, resources, and activities?

Response: Per this recommendation, CS-19 plans to delineate the different needs of the two geographic areas in more depth. REACH workplans will offer similar trainings in both areas, and CS-19 staff and activities will continue to coordinate with REACH. Nonetheless, some parts of Jawzjan will be starting from scratch, whereas CS-19 efforts in Andkhoy will focus on building staff capacity and reaching the remote populations. Staff will communicate with REACH on further defining differences in training, activity and resource needs.

5. IHFA Results

Will facility indicators be applied to the six clinics supported by CS-19 in Shibergan?

Response: The six clinics currently not permanent locations, but health teams offering services in community structures. The MOH is planning to build facilities to house the clinics within the CS-19 project lifetime. Once the facilities are constructed, CS-19 facility indicators can be applied. We responded that yes the indicators will be similar only once there are clinics built in these locations. These are health teams offering services in community structures. There were no facilities here.

6. Male involvement

It is clear that the MOH has no concrete plans to target male decision makers (heads of household, etc.) that might influence maternal nutrition and care. To what extent might greater male participation be encouraged in all aspects of program planning?

Response: Although perhaps not clear in the DIP document, male involvement is part of CS-19 activities. Birth planning education targets the male family members, and the focus group discussion baseline (included in Annex section) included discussions with men on health-seeking behaviors, birth planning and family planning/child spacing. CS-19 plans to use this data to build additional strategies for encouraging male involvement.

7. Indicators

The nutrition intervention only lists two indicators. Why is nutritional status of the child, measured in the Rapid Catch, not measured in the project?

There is no indicator for iodized salt, although it is a program intervention.

Response: The statistic for underweight children listed in the DIP is incorrect, and was corrected during the Mini-U. The percentage of children at -2 weight-for-age z-score (WAZ) is **24%**, and not 56% (as stated in the DIP document.) However, CS-19 has added nutritional status as a project indicator, and will measure WAZ. Other NGOs are involved with working on iodized salt distribution and education, and CS-19 will support these activities, but not play a major role and will not include any iodized salt indicator.

9. Low EPI coverage

Components of the EPI intervention do not include how to deal with high dropout rates. SC needs to clarify how it will translate training achievements at the provincial level into activities at the community level.

Response: CS-19, REACH, and CHW staff are currently working on plans to trace EPI defaulters through community outreach. However much of community level activities are part of the MOH package-and the role of CS-19 is focused on supporting these activities through trainings.

10. Saving Newborn Lives

It is good that the project has included newborn and post-partum activities. How will lessons learned from Saving Newborn Lives influence this project?

Response: This is an excellent recommendation, and Save the Children plans to use the experiences and lessons learned from the Saving Newborn Lives program in Pakistan to help inform CS-19 activities.

F. PROGRAM MANAGEMENT SYSTEM

1. Financial Management System

SC will continue to provide managerial and logistical support to hire and support project staff. All financial and administrative procedures will be compatible with SC's standard operating procedures and comply with USAID regulations. To this end, the Senior Finance Officer and Program Manager based in Shiberghan liaise with SC central Field Office staff in Kabul, including the Finance Officer and the Deputy Director of Operations (DD Ops), on a regular basis to discuss project budgeting and financing requirements and program direction. Quarterly and annual budgets are developed in Kabul by the Finance team, in consultation with the DD Ops. Expenditures are recorded as they are made. Finance reports are reviewed monthly in Shiberghan by the Program Manager and by finance staff, are submitted to the Field Office Finance Department (Kabul) monthly, and are incorporated into the Field Office's monthly report to SC headquarters in Westport.

2. Human Resources

Save the Children has a strong team in the field offices in Afghanistan who are supporting this project. These staff include:

Field Office Director, Deputy Director Operations and Deputy Director Communication, Advocacy & Program Support: Provide overall guidance and representation with MOH, USAID, REACH/MSH and other organizations.

Manager-Finance: Responsible for fiscal oversight and financial reporting in compliance with grant policies and procedures.

Manager-Administration: Responsible for administrative oversight in compliance with grant policies and procedures.

Program Manager-Balkh/Jawzjan: Responsible for oversight of all aspects of the project, including oversight of services provided, technical training content, technical (health) staff training and supervision and support (administration and finance.).

CS-19 Coordinator: Responsible for on-site management, and for assisting the Program Manager with planning and implementing CS-19 activities, especially monitoring the development of community-based providers and ensuring productive collaboration with the PHO and local partners. The coordinator is responsible for organizing and implementing training activities for all CS interventions, including materials development and district health planning and management for SC and MOH staff. The coordinator provides technical support for trainings organized by the PHO and health education sessions conducted at the community level by the rural MOH health facility staff in Jawzjan Province.

Senior EPI Officer: Responsible to plan, monitor and evaluate project EPI activities; ensure coordination with other SC health programs; train MOH staff; undertake community advocacy in target areas; support MOH district and provincial management teams (DMTs and PMTs) with planning, organization of supplies and communication of routine EPI programs with the aim of improved coverage and quality of programming; support the planning, implementation and evaluation of an EPI awareness-raising program in communities in target areas with the goal of increased demand for immunization services; support MOH campaigns (national immunization days, and tetanus toxoid and measles) through planning, supervision and monitoring, as appropriate, in target areas; provide supervisor with statistical and narrative reports for donor reporting on EPI programming in the target areas; coordinate with MOH, UNICEF and WHO in EPI-related activities; work closely with other senior officers, ensuring a coordinated implementation of all the components of the project.

Senior CDD/ARI Officer: Plan, implement and monitor SC CDD/ARI programs in target areas; ensure MOH staff and other health care providers in facilities in the target areas are well trained in providing CDD/ARI services following WHO guidelines; monitor and provide feedback to trained staff on appropriate case management of childhood illnesses in facilities; monitor and support community health staff as they implement a community based childhood illness program; coordinate CDD/ARI training activities, including training logistics; provide technical support to provincial and district government health services to ensure implementation of appropriate case management of childhood illnesses and appropriate organization of child health services; provide supervisor with statistical and narrative information on CDD and ARI in target areas; work closely with other senior officers, ensuring a coordinated implementation of all project components.

Senior RH Health Officer: Plan, implement and monitor SC RH programs in target areas; ensure the appropriate MOH staff and other health care providers in facilities in the target areas are well trained in providing RH services; monitor and provide feedback to trained staff on providing RH services in facilities and community; help identify district-based MCH promoters for a community based RH program, and supervise, and evaluate them; develop, pilot, and finalize a package of appropriate health education materials to promote RH; coordinate RH training, including logistics; provide technical support to provincial and district government health service providers to ensure coordination and implementation of appropriate RH services; provide supervisor with statistical and narrative information on the RH program in the target areas; work closely with other senior officers, ensuring a coordinated implementation of all the components of the project.

Senior BC Health Officer: Plan, implement, and monitor BC-related activities within the health program in targeted areas; use baseline data, monitoring data, and other information sources to identify and document BC needs in both the target area and in health programs nationwide; develop a plan to address the selected BC needs, identifying target groups, methodology and specific messages; review behavioral change materials available/in use; identify and order appropriate (existing) materials for the program; coordinate the development of new materials; actively contribute to all trainings developed and implemented in the target areas to ensure inclusion of BC in the curriculum; implement training sessions as appropriate; contribute to the development of a M&E system for BC; work closely with other senior officers, ensuring a coordinated implementation of all the components of the project.

Health Officers (2): Monitor and integrate the Community Health Worker (CHW) Program within the MOH's basic primary health services package (BPHS) program throughout the province; ensure strong links between the CHWs and health facilities; ensure the regular monitoring and support of CHWs; identify training needs and organize training accordingly; organize the work schedule of CHWs to ensure geographical coverage; and participate in meetings with community representative and volunteers.

MCH Promoters (10): Assist in the implementation of BPHS services; train and provide refresher courses for CHWs; implement BCC activities; take part in and implement community mobilization; support caretakers through counseling; liaise with local leaders, arrange committee meetings; and submit monthly reports.

Senior Finance Officer (2): Responsible for keeping financial records and for financial reporting.

Senior Officer Administration, Officer Administration Logistics, Officer Administration Support (2): Responsible for procurement, record keeping, stores and general administration of the office.

Backstopping and Technical Assistance from SC's Headquarters and the Regional Health Advisor: Regular technical and administrative assistance and monitoring to Afghanistan from SC's home office in support of the project include provision of technical materials for baseline assessments; joint writing, review and revision of the Detailed Implementation Plan, annual reports, and other technical documents; participation in mid-term and final evaluations; annual program review and technical assistance visits; technical backstopping and encouragement to Afghanistan's CS/health team to seek technical materials and guidance from outside sources, including the home office; prompt responses to queries; and regular internal and external auditing. Key SC headquarters staff supporting CS-19 include: Kathryn Bolles, Child Survival Specialist, responsible for technical backstopping and guidance; and Carmen Weder, Office of Health Manager. Dr. Tariq Ihsan, Regional Health Advisor for Asia, based in Islamabad, provides technical assistance and oversight, particularly with regard to planning, and baseline and other assessments.

3. Communication system and team development

The collection and use of data for CS-19 project management is integrated with the national health policy, and CS-19 staff coordinates activities with the MOH and other NGOs in the project area through the monthly PHCC meetings. At the facility and community level, for the purposes of maintaining uniformity of reporting throughout Jawzjan Province, the MOH monthly reporting

forms are used unaltered in Jawzjan and the Andkhoy cluster districts. MOH and SC joint supervisory teams provide support to health facility staff on a monthly basis, reviewing data analysis and actions taken by facilities and communities. The joint supervisory team consolidates data from health facilities, calculates key indicators, identifies problems, and plans a course of action.

Additionally, all of Save the Children's health staff members, including those from Balkh, Jawzjan and Kabul network regularly – in general, during program learning group meetings, and for specific activities, e.g., a non-CS19 health staff member from Mazar-i Sharif (Balkh) is supporting PDQ training. Additionally, the Program Manager holds regular Program Management Team (PMT) meetings for all program staff in both Jawzjan and Balkh.

4. Local partner relationships

CS-19 and REACH staff have good relationships with the Community Health Councils and local leaders as well as district and provincial governors and leaders. Staff attends Community Health Council meetings regularly and these meetings provide a forum to share information, review successes and challenges, solve problems and plan. In preparation for and during meetings, partners receive training on meeting facilitation, setting priorities, problem-solving, organizational structure, team building, and partnering.

5. PVO coordination/collaboration in country

SC coordinates plans and activities with other PVOs in Jawzjan, nearby provinces and throughout Afghanistan. This includes attending monthly Provincial Health Coordination Committee (PHCC) meetings which are attended by approximately five PVOs and international organizations. CS-19 staff uses this opportunity to coordinate and collaborate on health issues and activities throughout the province. SC's primary PVO partner in Jawzjan is SC/UK because they are also implementing REACH activities. Coordination and collaboration have included attending each organization's trainings, holding joint meetings, and ongoing communication about program implementation to ensure there is no duplication of effort.

6. Information management

Process to Gather, Analyze, and Use Data in Project Management in Relation to MOH HIS

Growth monitoring and management of childhood malnutrition, ARI, and diarrhea: Health worker practices in ARI case management and ORT corners at every MOH health facility are being monitored on a bi-monthly basis by MOH and SC supervisors using a checklist. CS and MOH staff will introduce periodic exit interviews with mothers during these supervisory visits. ARI reporting by health workers includes recording all children in the patient log, indicating age of the child, diagnosis and treatment. MOH staff submit ARI and CDD patient/disease monthly reports and ORT corner reports, with the total number of children treated by age and diagnosis, to the PHO on a monthly basis.

Bi-monthly growth monitoring (GM) sessions at health facilities are regularly conducted in four health facilities using GM cards. During supervisory visits conducted by an MOH/SC joint supervisory team, members monitor performance of health workers by checklist and review of daily and permanent registers.

Health workers responsible for immunization report the total number of children immunized by antigen and dose, and track and report on the DPT dropout rate for their area. Immunization cards have been introduced in all districts. When the cards are given to mothers, duplicate records (daily and permanent immunization registers) are kept at the health facility. By referring to the permanent register, the health worker is able to determine the number and names of the children due for vaccination so that timely immunization activities can be planned with and for the vaccinators. The permanent register is used to identify dropouts. After compiling the monthly report, facilities prepare a list of all defaulters and dropouts and give this to the EPI contact persons (community members), who are responsible to track the defaulters for participation in the next immunization session.

MNC and child registry system: CS-19 staff has introduced ante-natal, post-natal, GM and birth registration books in all the health facilities in Jawzjan Province, and midwives are now trained to record all ante- and post-natal visits, GM and births.

G. WORKPLAN

Workplan for Year 2

EPI (20%)														
Indicator 2. % of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (card.)														
Indicator 3. % of infants who received DPT3.														
Indicator 4. % of 12-23 month olds who received the measles vaccine (recall.)														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
EPI Refresher					X								MOH EPI and CS-19 EPI officer	20 doctors, 20 vaccinators and 15 MCH promoters
Support MOH in NIDs								X	X		X	X	CS-19 EPI Officer, MOH EPI Manager, WHO PPO	20 doctors, 100 vaccinators (including volunteers) 4 NIDS sessions
EPI micro plan meetings			X							X			CS-19 EPI Officer, MOH EPI Manager, WHO & UNICEF PPOs	Two micro-planning sessions
Immunization coverage data collection (support to PHO)	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 EPI Officer & MOH EPI manager	20 monthly EPI reports with feedback
EPI IEC materials used in the health facilities and communities	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 MCH promoters, vaccinators	IEC materials developed and displayed in HF. Use assessed during supervisory visit (3 reports)
EPI joint monitoring and supervision visits using EPI checklists		X		X		X		X		X		X	CS-19 EPI Officer & MOH EPI manager	Six monitoring visits completing 20 facilities each time
Monthly monitoring and supervision by PHO staff	X	X	X	X	X	X	X	X	X	X	X	X	MOH EPI manager	Each visit targeting four clinics

Feedback on immunization coverage to PHCC	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 coordinator, EPI Officer & MOH EPI manager	PHCC and NGOs
CDD (15%)														
Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness. Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness. Indicator 7. % of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment. Indicator 16. % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month. Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented. Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home. Indicator 19. % of caretakers of <5s know at least 2 aspects of home care. Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse. Indicator 21. % of severely ill <5s classified correctly in MOH facilities. Indicator 24. % of <5 diarrhea cases treated correctly in MOH facilities.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
CDD refresher training								X					MOH ARI / CDD officer and CS-19 ARI / CDD officer	30 doctors and 10 MCH promoters
Implementation of CDD checklist (monitoring)		X			X			X			X		MOH ARI/CDD officer and CS-19 ARI/CDD officer	Checklist used in 20 health facilities. Two compiled reports.
Observation of sick child management (Child with diarrhea, ARI and fever)					X			X			X		ARI/CDD CS-19 officer & MOH pediatrician	300 observations
Exit interviews with caregivers of child suffering from ARI/diarrhea/Fever					X			X			X		MCH promoters	300 caregivers

MCH promoters work with CHWs	X	X	X	X	X	X	X	X	X	X	X	X	MCH promoters	10 MCH promoters will cover with at least 60 health posts
CCM Training								X (CDD)					CS-19 ARI/CDD Officer	8 MOH staff 20 CHWs Qarqin 12 CHWs Khamyab
CCM start up						X	X	X	X	X	X	X	CHWs	32 CHWs in Qarqin and Khamyab
CCM documentation								X		X		X	CS-19 ARI/CDD officer, MCH promoter in Qarqin and Khamyab	4 monitoring and supervision visits. One report at the end of Year 2
On the spot technical support to PHO technical officers		X			X			X			X		CS-19 ARI/CDD officer	4 CDD monitoring & supervision with on spot TA.
IEC CDD materials used in the health facilities and communities	X	X	X	X	X	X	X	X	X	X	X	X	MOH HF staff, CHWs & MCH promoters	13,200 WRA (10 promoters x 22 days x 10WRAx 6 months)

ARI (20%)														
Indicator 5. % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness. Indicator 6. % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness. Indicator 8. % of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source. Indicator 14. % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment. Indicator 16. % of MOH facilities with 1 or more stock-out of essential drugs last month. Indicator 17. CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented. Indicator 18. % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home. Indicator 19. % of caretakers of <5s know at least 2 aspects of home care. Indicator 20. % of caretakers of <5s know at least 2 signs of when to return if child gets worse. Indicator 21. % of severely ill <5s classified correctly in MOH facilities. Indicator 23. % of <5 ARI cases treated correctly in MOH facilities.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
ARI case management training		X											CS-19 ARI/CDD officers and MOH pediatrician	30 doctors and 10 MCH promoters
Implementation of ARI checklist														Please refer to observation and exit interviews in CDD section
MCH promoters work with CHWs	X	X	X	X	X	X	X	X	X	X	X	X	MCH promoters	10 MCH promoters will cover with at least 60 health posts
CCM Training					X (ARI)								CS-19 ARI/CDD Officer	8 MOH staff 20 CHWs Qarqin 12 CHWs Khamyab
CCM start up						X	X	X	X	X	X	X	CHWs	32 CHWs in Qarqin and Khamyab

CCM documentation								X		X		X	CS-19 ARI/CDD officer, MCH promoter in Qarqin and Khamyab	4 monitoring and supervision visits. One report at the end of Year 2
On the spot technical support to PHO technical officers			X			X			X			X	CS-19 ARI/CDD officer	4 CDD monitoring & supervision with on spot TA.
IEC ARI/fever materials used in the health facilities and communities	X	X	X	X	X	X	X	X	X	X	X	X	MOH HF staff, CHWs & MCH promoters	13,200 WRA (10 promoters x 22 days x 10WRAs x 6 months)
Nutrition (15%)														
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours.														
Indicator 12. % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
Development/or procurement of IEC materials on nutrition and growth.			X	X	X								CS-19 BC officer with MOH, WHO, UNICEF and NGOs	Materials available on weaning, supplementary feeding, foods, micronutrients, breastfeeding
GMP Technical support			X		X		X		X		X		CS-19 MNC officer and PHO nutrition Officer	Five technical support visits covering 20 health facilities
Logistic support for iodized salt distribution						X	X		X	X			CS-19 BC Officer, UNICEF and PHO staff	Availability of iodized salt in at least 7 districts.

Community mobilization technical support														
PD/Hearth Training				X									SC's CS specialist	PHO, NGOs, SC REACH staff
PD/Hearth Training in pilot area					X								Advisor, CS-19 coordinator	HF staff, CHWs and CHC members, MCH promoters in pilot areas
PD Inquiry and establishment of Hearth					X	X	X	X	X	X	X	X	Advisor CS-19 coordinator MCH promoters CHWs	Three pilot areas
PD/Hearth monitoring and documentation						X		X		X		X	CS-19 MNC officer, PHC nutrition officer	7 monthly reports 4 monitoring reports

MNC (30%)														
Indicator 1. % of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months old. Indicator 9. % of 0-23 month olds whose delivery was attended by skilled health personnel. Indicator 10. % of mothers who had at least one postpartum check-up. Indicator 13. % of mothers able to report at least two known maternal danger signs during the postpartum period. Indicator 15. % of MOH facilities with female health workers.														
Major Activities	2004			2005									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
MNC refresher (focusing on birth planning)					X								CS-19 MNC officer	40 BHC and CHC staff and 10 MCH promoters

Collaborate with SC Community Midwife Training		X			X			X			X		CS-19 MNC officer	Four meetings
Assist MSH/USAID in the development of MNC/birth planning messages	X			X			X						CS-19 MNC officer	Attend two meetings with MSH/USAID Field-test materials on MNC/birth planning
Procure MNC/birth planning BC materials				X									Save staff	Availability of MNC/birth planning materials
Collaborate with REACH/BPHS staff	X		X		X		X		X		X		CS-19 coordinator and REACH coordinator	Six coordination meetings
Technical support on community mobilization (birth planning/community alarm and transportation)							X						CS-19 MNC and CS-19 coordinator	PHO staff NGO staff
FP TOT training for BPHS/REACH staff						X							CS-19 MNC officer	20 MOH staff and 10 MCH promoters
Implementation of bimonthly supervision	X		X		X		X		X		X		CS-19 MNC officer and MOH MCH manager	Six joint monitoring visits covering 20 health facilities

All interventions														
Indicator 22. CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality.														
Indicator 25. % of mothers receiving general information or advice on health or nutrition from a member of the informal community network.														
Indicator 26. % of CDQ Quality Improvement Committees including at least one female participant.														
Major Activities	2003			2004									Personnel	Benchmarks
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		Year 2
Attend PHCC monthly meetings	X	X	X	X	X	X	X	X	X	X	X	X	CS-19 coordinator	Monthly attendance and representation
CDQ training													CS Specialist BC Officer	
CDQ implementation in two pilot areas													BC Officer	
Equity task force established and action plan development		X		X		X		X		X		X		
CS-19 Intervention task forces monitoring meetings		X		X		X		X		X		X		
Transportation provided for health staff at 6 MOH clinics	X	X	X	X	X	X	X	X	X	X	X	X		
Annual reports														

ANNEX I

Gap Analysis

Cooperative Agreement No. GHS-A-00-03-00011-00

Gap Analysis Report for CS-19 baseline Jawzjan, Afghanistan

Prepared by

Save the Children/US

August-September, 2004

EXECUTIVE SUMMARY

Save the Children USA's (Save the Children) child survival project (CS-19) in Jawzjan province of northern Afghanistan aims to reduce maternal and newborn mortality through sustainably improving community awareness, promoting healthy practices, increasing access, and improving quality services and utilization of MCH services. The e analysis compared services and utilization in the Andkhoy cluster of villages and Jawzjan province. Save the Children began supporting interventions in the Andkhoy cluster in 1995. Interventions in Jawzjan province started in 1999. Statistically an estimated 15 percent of all pregnancies involve complications that require emergency obstetric care services. This "gap analysis" helped to assess the availability of life-saving interventions at three levels of care:

- the household/community level;
- the peripheral facilities level; and
- at the hospital level.

The gap analysis also determined gaps in service interventions and identified program recommendations that address the gaps.

Community level Findings

- 71 percent of pregnant mothers received iron and folic acid tablets from the local MOH clinics in Andkhoy cluster whereas only 21 percent received iron tablets from a few NGO supported MOH facilities in Jawzjan province.
- 79 percent of pregnant mothers received TT2 vaccine in Andkhoy cluster whereas KPC survey results indicated 28 percent coverage in Jawzjan district.
- 84 percent of mothers in Andkhoy received a postnatal visit by a health worker, out of which 49 percent received a vitamin A supplement.
- An approximate 67 percent of mothers in Andkhoy district knew at least two or more danger signs during pregnancy and 70 percent knew two or more danger signs during delivery.
- 13 percent¹ of mothers in Andkhoy cluster and 28 percent² in districts of Jawzjan were delivered by skilled birth attendant.
- 11 percent of mothers believed in the advantage of delaying bathing the baby, as revealed in the past KPC surveys
- Initiation of breastfeeding within eight hours after delivery in Andkhoy cluster and in other districts of Jawzjan is 76 percent and 61 percent respectively.
- In the Andkhoy cluster, 57 percent of TTBAAs and 43 percent of skilled health workers conducted postpartum visits. In Jawzjan only 29 percent mothers reported that their health was checked after childbirth/delivery.
- Only in Andkhoy cluster, all pregnant mothers attending antenatal sessions received birth-planning messages. These health education sessions however do not involve husbands and other members of the family like mother-in-laws and other elders.

¹ KPC survey, Andkhoy cluster, January 2003

² KPC survey, Jawzjan, November 2003

Peripheral level facilities (BEmOC) Findings

- In Andkhoy, 89 percent of pregnant mothers sought antenatal care during their last pregnancy and of these 96 percent sought ANC at the MOH health facilities with 70 percent attending antenatal clinic at least three times during her pregnancy.
- Health workers are not trained, equipped, or have the supplies to manage obstetric complications.
- In Andkhoy cluster, the rural health facilities did not provide labor and delivery care services nor did they have appropriate space or equipment. Most deliveries occurred at home. Lack of water, toilets, delivery room, privacy and equipment made the peripheral health facilities unable to provide delivery services of good quality. There was a lack of transport; communication links with referral hospitals and lack of 24 hours a day/7 days a week service delivery (most health facilities only operated for five hours 8am to 1pm).
- Long distances to the health facilities and lack of transportation prohibited mothers and newborns from receiving facility-based postpartum care.
- Except in the Andkhoy cluster, generally, the MOH's staff knowledge of PPC was limited to mother's abdominal examination and newborn's cord care.

Hospital level (CEmOC) or EmOC Findings

This portion provides information and comparison on the EmOC services between three main tertiary level hospitals. Aqcha district hospital and Shiberghan provincial hospital provided antenatal care services to their few registered clients through their MCH departments; but the antenatal service package did not include birth planning education and a danger signs approach as was the case in the Andkhoy district hospital. A risk-approach to pregnancy care was used. Facilities to screen, test and treat STDs including syphilis were only available at Shiberghan hospital. Both the provincial and district hospitals at Andkhoy and Aqcha had an operation theatre and adequate anesthetic equipment.

- Andkhoy district and Shiberghan provincial hospitals had adequate resuscitation equipment. Whereas Aqcha hospital lacked the resuscitation equipment.
- Both Andkhoy district and Shiberghan provincial hospitals carried out C-section when required and used other surgical instruments. Only Shiberghan provincial hospital had a complete set of delivery forceps.
- Blood storage was only present at Shiberghan provincial hospital.
- No hospital used a partograph to monitor deliveries. There was a lack of infection control procedures. Mothers and newborns stay in the hospital after a normal delivery was too short to provide quality postpartum care. Many maternal and newborn complications arise within the first three days after delivery but in these hospitals the mother was discharged to go home within 6 hours of birth.
- There is no feedback system between the provincial/district hospitals and the peripheral facilities and therefore no postpartum care was actively extended through peripheral staff. Postpartum care at six weeks was generally absent.
- The district hospital in Andkhoy received essential drugs from the provincial health office located in Shiberghan. Frequent stock out of essential drugs were noted in Andkhoy district hospital.
- The emergency unit of all the three hospitals operated 24 hrs a day, seven days a week. Each hospital had a roster that showed two doctors, two nurses and two cleaners on duty. Each hospital had an ambulance (Aqcha had a rented car). There was a lack of funds for vehicle

maintenance, petrol, oil and lubricants. Most of the time ambulances were not available for EmOC referrals. Aqcha used a rented a vehicle and its driver refused to bring patients from remote villages that had bad roads.

HHC Linkages Findings

Trained TBAS can act as an important link between the communities and the peripheral health facilities.

- Linkages were stronger between community and health facility staff where there were established community health committees
- Hospitals worked independently and had limited linkages with the either the peripheral facilities or the other private facilities within the district or province.
- There was no feedback system with the peripheral health facilities to inform about the status of the mothers and newborns, referred to or back, at any level of the continuum of care.

Discussion Points

- Integration of tetanus toxoid (TT) vaccine within antenatal care (ANC) services, community education and motivation activities, effective use of community networks, outreach activities and recruiting and training female vaccinators are important strategies for increasing TT coverage.
- It is important that a birth preparedness/planning strategy is integrated within the whole service package and implemented through community agents and health care providers – to ensure that families are proactive in making birth plans and that women with obstetric complications access EmOC service in timely manner.
- To date, pregnant mothers have always been targeted by health education activities. The KPC surveys showed that this effort increased their knowledge - but has this actually helped them to seek prompt care outside the home when they develop complications?
- Both district and provincial hospitals had the structure and space to provide the eight CEmOC functions. A complete health facility assessment needs to be conducted to reflect on the infrastructure, equipments, supplies and other administrative, logistical and managerial issues and needs that hinder the provision of services.
- The lack of systems of supervision and infection control was a major concern. It would be beneficial to involve key hospital staff in training, monitoring and supervision of such activities.
- The linkage between the peripheral facilities and hospitals were not established. These linkages are important for the functioning of the EmOC services and therefore when developing a referral system these linkages must be taken into account.

SUGGESTIONS/RECOMMENDATIONS

- Integrate provision of micronutrients within ANC services. The CS-19 coordinator and BCC Officer should work with the MOH and UNICEF to enhance their social marketing efforts for iodized salt and provision of other micronutrient supplements.
- Establish links between midwives, CHWs and the existing TTBA.
- Assist in the national effort to develop birth planning materials, strategies and concepts through training and other community mobilization efforts
- Integrate malaria prophylaxis within antenatal care services in the areas where malaria is endemic
- Review and refine the existing MNC training module to incorporate essential postpartum maternal and newborn care elements.

- Ensure procurement of MNC health education materials with key postpartum care messages. Either use existing materials if available in Afghanistan or adapt health education materials developed in Pakistan for the Afghan refugee primary health care program.
- Develop and implement a support mechanism for the trained midwife to enhance her role in MNC.
- Based on the skills midwives gain from their 18-month training course – prioritize EOC and EmOC services that she should provide at the peripheral facility and community level.
- Improve the environment in the health facility to ensure delivery of good quality EOC services and EmOC services 24 hours/seven days a week.
- Develop infrastructure/supplies and systems of supervised infection control at peripheral health facilities and district hospitals.
- Develop and use a community based referral system. Establish an efficient referral and feedback system between the district and the provincial hospitals.

1. Background:

A study undertaken by the Centers for Disease Control and Prevention, UNICEF and the Afghan Ministry of Public Health in 2002 revealed shocking maternal mortality rate at 1,600 deaths per 100,000 live births in Afghanistan - one of the highest in the world - leading to an estimated 515,000 maternal deaths every year as a result of pregnancy and childbirth.

The research revealed that more than 40 per cent of maternal deaths are caused by complications in pregnancy that are preventable, yet most women had encountered barriers to health care at all three levels such as lack of skilled health providers, lack of basic obstetric care facility at the peripheral and district hospitals, long distances to travel to locate skilled providers and lack of financial resources. The research recommended developing strategies to increase access to skilled prenatal care, to teach women and their families about healthy pregnancies and deliveries; screening and treating complications such as pre-eclampsia, anemia, and malaria and increasing access to skilled birth attendants (physicians and midwives).

2. Household to Hospital Continuum of Care³:

Each year, throughout the world, almost 600,000 women die of complications during pregnancy, delivery and the postpartum period. About 99 percent occur in developing countries and most of these deaths could be prevented. The most common causes of death included hemorrhage, infection, eclampsia, obstructed labor, unsafe abortion and other direct and indirect causes. For every death, an estimated 15 to 30 women suffer from chronic illnesses or injuries related to pregnancy, for example obstetric fistula. Timely intervention is critical to saving lives of women with emergency complications. The estimated average interval from the onset of complications to death from major obstetric causes are as below.

³ Description of this section is based on information received at Safe Motherhood workshop in Thailand, July 2004

<u>Complication</u>	<u>Average time to death</u>
Antepartum hemorrhage	12 hours
Postpartum hemorrhage	2 hours
Ruptured uterus	1 day
Eclampsia	2 days
Obstructed labor	3 days
Puerperal sepsis	6 days

An estimated 15 percent of all pregnancies will result in complications; however we cannot predict which ones and therefore all pregnant women need access to EmOC services. There are many factors that prevent hundred of thousands of women from accessing EmOC. The “Three delays model” outlines the main factors which prevent or delay access to EmOC.

The Three Delays

1. Delay in decision making to seek care outside home
 - Lack of understanding of complications
 - Acceptance of maternal death
 - Low status of women
 - Socio-cultural barriers to seeking care
2. Delay in reaching care
 - Distance, cost, poor organization
3. Delay in receiving care
 - Supplies, personnel
 - Lack of guidelines and protocols on management of obstetric complications.
 - Poorly trained staff with punitive attitude
 - Finances

While it is important to identify the delay factors and find ways to address these, a minimum package of services (EOC) must be made available to all pregnant women that should include antenatal care, safe delivery, postnatal care, identification of complications and referral to emergency obstetric care services (EmOC) at the peripheral and/or referral health facilities. EmOC includes elements of obstetric care needed for the management of complications arising during pregnancy, delivery and the postpartum period. For example, during transport or at the peripheral health facility initial stabilization of the patient while proper referral is organized to a referral facility. Therefore while planning it is important to consider three levels to ensure survival of women with obstetric complications:

- a) The household level where most women in developing countries deliver;
- b) The peripheral health facilities level which are accessible to most women and
- c) The referral level or hospitals where comprehensive obstetric care is provided.

Combining all these levels and ensuring that important EmOC services or functions are available at each – forms a household to hospital continuum of care model.

There are eight key EmOC functions that are crucial to the survival of a woman with obstetric complications. The first six of these must be available at the peripheral health facility levels. The eight EmOC functions are:

1. antibiotics (intravenous or by injection);
2. oxytocic drugs (IV, IM);

3. anticonvulsants (IV, IM);
4. manual removal of retained placenta;
5. removal of retained products (e.g. Using MVA kit);
6. assisted vaginal delivery (vacuum extraction, forceps delivery);
7. surgery (cesarean section); and
8. blood transfusion

3. Introduction:

Beginning in November 2003, Save the Children USA in partnership with the Ministry of Health initiated CS-19 in Jawzjan province in northern Afghanistan. The main aim of CS-19 project is to reduce maternal and newborn mortality through sustainable improvements in community awareness, healthy practices, increased access, quality services and utilization of MCH services.

Jawzjan province has a total population of about 707,510 including 155,800 women aged 15 to 49 years old. It consists of 14 districts and approximately 332 villages, some of which are located in remote areas with no access to transportation and tarmac roads. In order to ensure good quality Maternal and newborn care (M&NC) services Save the Children conducted a “Gap Analysis” in both the Andkhoy cluster⁴ and Jawzjan province. The Gap Analysis examined the availability of basic maternal and newborn services at the household/community level, peripheral facilities and hospitals. The specific objectives of conducting the gap analysis were to:

1. assess the availability of life-saving interventions at 3 levels of care: household/community, peripheral and district level;
2. determine gaps in interventions; and
3. identify program recommendations to guide planning to address the gaps.

Between August 8 to 18 2004, Ms. Asma Akber, the Deputy Program Manager Saving Newborn Lives, Pakistan Field Office conducted this assessment with the help of Save the Children’s Dr. Honey Mukhtar, CS-19 Coordinator. Dr. Aftab Tariq Ihsan, Asia Health Advisor provided overall assistance and guidance.

3. Methodology

Three basic methods were used to collect information, analyze gaps, and recommend strategies for action. These methods were:

1. group discussions;
2. observation of services and questions; and
3. a review of secondary sources.

3.1. Group discussions

Save the Children held five group discussions with the health workers working in the basic health facilities and district hospitals. The details of the discussion group members are detailed below.

⁴ Andkhoy cluster is a cluster of four districts including Andkhoy, Qorghon, Qaramqol and Khanecharbagh.

- Two group discussions with health staff working at the peripheral health facilities (at BHCs).
- Two discussion sessions with MOH doctors working at Andkhoy Mother and Child (MCH) clinic and district hospitals.
- One discussion session with MOH staff working at the peripheral health facilities in other districts of Jawzjan province.

The health workers who participated in the group discussions were medical doctors (male and female) midwives, MCH promoters, lab technicians, vaccinators, and master trainers from the peripheral and hospital facilities.

3.2. Gap Analysis Tool

Staff used the Gap Analysis tool, designed by Save the Children to examine the availability of MNC and EmOC services at the three levels⁵ of the household to hospital continuum of care (HHC). The questions that guided the process were:

- **Step 1:** What are the interventions that promote maternal and newborn survival at the 3 levels of care?
- **Step 2:** What are the current practices in our program?
- **Step 3:** What are the gaps in programming? What should be done to improve health outcomes for women and their newborns?
- **Step 4:** What do we intend to do to fill the **gaps**

Before Save the Children used the gap analysis tool, staff sensitized the participants to the concept of the HHC and three delays models. Participants became familiar with the key life saving interventions at each level of the HHC model. Most, if not all, of the key life saving interventions must be available at the household/community, peripheral health facility and referral/district hospitals levels in order to meet maternal obstetric needs and to ensure a positive pregnancy outcome. The key interventions of the HHC model are listed below:

1. Antenatal care clinics at the peripheral and district hospitals with staff trained to provide basic antenatal care services including the ability to detect and manage some obstetric complications. These facilities have appropriate equipment and supplies available including Magnesium Sulphate (MgSO₄) for severe pre-eclampsia/eclampsia
2. Pregnant mothers, their family members, traditional birth attendants and skilled birth attendants are able to recognize danger signs during pregnancy, childbirth and postpartum period and are able to take timely actions (seek care from skilled providers on time).
3. Pregnant mothers and their family members make and implement birth plans which include saving money, identifying transportation, identifying a blood donor, deciding the place of delivery and identifying skilled birth attendants.
4. Mothers have adequate nutrition especially consumption of micronutrients such as iron, folic acid and iodized salt during pregnancy and vitamin A during the postpartum period.
5. Prevention of Malaria: Pregnant mothers and their family members use insecticide treated bed nets and pregnant mothers taking prophylactic Chloroquin tablets to prevent malaria.
6. Prevention of neonatal tetanus: Pregnant mothers immunized with tetanus toxoid vaccine (TT).
7. Syphilis screening and treatment during pregnancy to prevent ophthalmic neonatarum.

⁵ Home, peripheral health facility and hospital.

8. Safe Management of Labor & Delivery by skilled birth attendants including use of partograph to monitor labor and active management of the 3rd stage of labor; or in areas where a significant number of deliveries are attended by TBAs clean delivery and clean cord-cutting.
9. Peripheral clinics with skilled staff who are able to provide basic emergency obstetric care (BEOC) and other life saving services. Such as the ability to:
 - administer parenteral antibiotics, oxytocics, anticonvulsants/antihypertensives/sedatives for eclampsia/pre-eclampsia;
 - perform manual removal of placenta;
 - perform removal of retained products e.g. using Manual Vacuum Aspiration (MVA) kit;
 - perform assisted vaginal delivery (with forceps or by vacuum extraction);
 - perform external and internal bi-manual compression of uterus (with observation of aseptic techniques);
 - manage asphyxia – perform newborn resuscitation; and
 - refer patients promptly to higher level for further management of complications.
10. Immediate care of newborn after delivery (warming, drying, wrapping, initiation of breast feeding (BF) within one hour after birth where possible)
11. First aid treatment for postpartum hemorrhage: such as external bi-manual compression (BMC) of uterus, use of (oral/IM/IV) oxytocics, use of misoprostol (if feasible), prompt referral for treatment, hydration with oral fluids and initiation of early suckling, encourage passing of urine.
12. Management of birth asphyxia: using resuscitation techniques.
13. Trained TBAs and skilled attendants recognize danger signs/onset of newborn (NB) complications such as birth asphyxia
14. TBAs or skilled birth attendants make postpartum visits within the first 72 hours after delivery (within six hours and on the third day) to promote:
 - a. immediate and exclusive breastfeeding
 - b. immunizations required by local policy at birth: BCG, OPV, HB1, Vit. K
 - c. clean cord care
 - d. prophylactic eye care to prevent ophthalmia neonatorum
15. Postpartum contact at 6 weeks to promote Family planning, breastfeeding, exclusive breastfeeding.
16. Availability of family planning (FP) services (for e.g.: through community based distributors of FP methods (CBD), community pharmacy shops, outreach services)
17. Prevention of childhood diseases by following national guidelines on childhood immunizations.

3.4. Observations and Questions

Save the Children made observational visits to four basic health centers (BHC) in the periphery, two district hospitals (Andkhoy and Aqcha) and one provincial hospital (Shiberghna).

3.5. Review of the secondary sources

Staff reviewed data of the last 6 months antenatal, postnatal and newborn services from a few facilities as well as existing documents like the KPC survey, CS-19 proposal and other relevant material.

4. Findings

4.1. Household and Community level

This part of the report looks at the practices of antenatal, labor and delivery and postpartum care at the household/community level. Statistics quoted for Andkhoy cluster are referenced from Andkhoy KPC survey conducted in January 2003 and statistics quoted for ‘other districts of Jawzjan’ are referenced from the Jawzjan KPC survey conducted in November 2003. References are also made to focus group discussions (FGDs) with communities conducted in between January and February 2004.

4.1.1. Pregnancy (antenatal period)

a. Access to iron and folate supplementation

Iron deficiency in pregnant women increases the chances of pre-term delivery and of delivering a low birth weight baby. It is therefore important that all pregnant women consume foods that are rich in iron and take iron supplementation in the form of oral pills.

The majority of pregnant women living in Andkhoy cluster have access to information and antenatal care services with iron and folic acid tablets provision during antenatal care sessions at MOH peripheral facilities. Save the Children has been involved in helping develop these services since 1995. In the Andkhoy cluster:

1. 71 percent of pregnant mothers took iron and folic acid tablets from the local MOH clinics;
2. mothers knew about nutrition during pregnancy and about foods that are rich in iron ; and
3. a higher proportion of pregnant women reported eating more than usual during pregnancy in Andkhoy cluster than in other districts of Jawzjan (33.2 percent versus only 6 percent).

Gaps:

There are many villages in Andkhoy cluster that, are located in remote areas where pregnant women do not have access to antenatal care clinics or iron and folic acid tablets. This situation gravities worse in other districts of Jawzjan province where only 21 percent of mothers received iron tablets from a few NGO supported MOH facilities – while NGOs like Save the Children USA and UK are establishing basic safe motherhood services at the peripheral facilities, to date many pregnant women have no access to basic safe motherhood services nor iron and folic acid tablets.

Eating habits (less eating) during pregnancy continue to remain poor in a significant number of mothers in both areas. The results of FGDs revealed that poor eating during pregnancy was related to gastric problems, nausea and vomiting as reported by many pregnant women and to mothers, especially those pregnant for the first time who want small babies.

The group discussions with MOH staff in both locations reveal that education regarding maternal nutrition, especially regarding foods that are rich in iron did not receive as much attention as it should have received. Maternal nutrition should be packaged as part of counseling during ANC sessions, however the MOH staff never received specific training in this regard nor do they have any maternal nutrition education materials.

b. Maternal immunization with tetanus toxoid

Tetanus toxoid (TT) vaccine prevents deaths of the newborns from neonatal tetanus. It is important that all pregnant women are adequately vaccinated with at least two doses of TT vaccine. The results of FDGs and KPC survey revealed that in Andkhoy cluster:

1. a pregnant woman who is aware of the importance of having TT vaccine could easily go to the nearest MOH clinic and get vaccinated. Knowledge of mothers and other family members regarding TT vaccine is very good and the demand is very high.
2. The overall coverage of pregnant mothers with TT2 vaccine was 79 percent. Because nearly 89 percent of mothers attended antenatal care sessions they also received TT vaccines.

The findings above confirm that Save the Children's effort to help the MOH to increase the coverage of TT vaccine among women of childbearing age and in particular among pregnant mothers have been successful. The strategies supported by Save the Children were the appointment of female vaccinators, health education through trained traditional birth attendants (TTBAs) and female outreach workers.

Gaps:

There are many villages in Andkhoy cluster that are remotely located and where pregnant women do not have access to antenatal care clinics or to TT vaccines. Group discussions with the MOH staff revealed that lack of transportation is one of the main reasons why vaccinators cannot reach these villages.

In other districts of Jawzjan generally the population is unaware of the importance of TT vaccine. The KPC survey results indicate that only 28 percent of pregnant women had received two doses of TT vaccine. While efforts are being made to improve the health systems at the district and community levels to ensure that all women of childbearing age receive TT vaccines, many clinics miss daily opportunities to vaccinate pregnant women because they lack antenatal care services and female vaccinators.

c. Vitamin A supplementation

Improved infant vitamin A status after postpartum supplementation may help to reduce vitamin A deficiency and enhance an infant's chances of survival. Unlike most other components of breast milk, which occur in relatively constant amounts, the vitamin A concentration of breast milk is highly dependent on the mother's nutritional status. Postpartum supplementation with vitamin A increases vitamin A content of breast milk for at least six months and this means more vitamin A for the breast-feeding infant. The KPC survey and review of the Government of Afghanistan's Basic Package of Health Services (BPHS) document revealed that:

1. The BPHS includes postpartum vitamin A supplementation.
2. In Andkhoy cluster, the majority of mothers (84 percent) received a postnatal visit by a health worker and almost half (49 percent) received vitamin A during the postpartum period.

Gaps:

Discussions with the MOH staff in Andkhoy cluster indicate that coverage for vitamin A is low because TTBAs and female outreach workers made most postnatal visits. They were not trained to

give vitamin A nor had supplies. Only those mothers who were visited by a facility staff member received vitamin A.

This information is not available for other districts in Jawzjan – however discussions with the MOH staff revealed that vitamin A is not provided during the postpartum period. The facility staffs are currently receiving training on MNC and the areas lack TTBA's and CHWs.

d. Iodine supplementation in areas with deficiencies

The cause of iodine deficiency is usually a chronically inadequate dietary intake because of low iodine content of the soil, common foods and water in a geographical zone. While there may not be immediate maternal and newborn threats, the consequences of severe iodine deficiency with regard to fetal brain damage are grave⁶. Iodine deficiency may also cause thyroid dysfunction associated with pregnancy in some cases. It is therefore important that the pregnant women increase their iodine intake (to recommended levels).

The MOH and UNICEF aim to ensure that adequate iodized salt is available in 2004 and have started a social marketing campaign including advertising through television and radio. MOH advised all peripheral health facility staff to promote the utilization of iodized salt and provided them with salt testing kits to monitor its use. UNICEF has also helped establish a local factory that produces packaged iodized salt. The MOH's Nutrition Officer monitors its quality. The MOH's staff recommended more advertisement through TV, inclusion of education to schoolchildren, conducting community based campaigns and decreasing the price of iodized salt, especially for school children.

Gaps:

In Jawzjan province 98.9 percent of kitchen salt tested negative for the presence of Iodine⁷. Group discussions with MOH staff indicated that most community members are either not aware of its presence or those who are, prefer other types because the iodized salt has granules, makes the food 'too salty' and is not as fine as the other salts available in the market.

e. Birth planning/preparedness

Discussions with the MOH staff in the Andkhoy cluster revealed that they have received training on the birth planning concept in early 2003. All pregnant mothers attending antenatal sessions receive birth-planning messages related to the following concepts:

1. recognition of danger signs and seeking medical help immediately;
2. knowing the expected date of delivery (EDD);
3. identification and contacting (booking) the skilled birth attendants or TTBA's for delivery;
4. identification of blood donors; and
5. arrangement of money

Focus group discussions carried out in February 2004 in Andkhoy cluster and in other districts of Jawzjan province revealed families do not think about birth planning as defined above; however they have certain beliefs and practices that can be a crucial part of a birth plan if practiced systematically. For example many families, especially in Andkhoy cluster, encourage pregnant

⁶ Susan Backman, Aarhus 2000

⁷ UNICEF MICs Survey - 2003

mothers to attend antenatal care sessions at their local MOH clinics; many families buy foods especially for the pregnant mother to consume; many families believe that rest is important during pregnancy; generally many are aware of danger signs and know where to seek care in case of an emergency situation.

Gaps:

Many families consider home delivery safe and only react when there is a complication. They waste a lot of time looking for money and transportation after the complication has arisen and upon reaching the referral hospital expend additional resources and time waiting to receive emergency care and looking for a blood donor.

Discussions with the staffs in Andkhoy cluster revealed that the birth planning education lacks solid strategies to involve husbands and other members of the family including mother-in-laws and community elders. The existing strategies mostly focus on educating pregnant women who are not the main decision makers.

BPHS have MNC as one of the interventions but it lacks birth-planning strategies. There are no documents to show the government's policy or use of the birth planning concept.

f. Recognition of danger signs during pregnancy and prompt referral

Pregnant mothers and their family members must be able to recognize danger signs if lives are to be saved. This knowledge empowers them to make timely and appropriate decisions regarding seeking care from skilled providers.

The KPC surveys (2003), FDGs with communities and discussions with the MOH staff revealed that:

1. The mothers' and their family members' knowledge regarding danger signs during pregnancy is very good in the Andkhoy cluster and that seeking prompt care from the female doctors working in Andkhoy district hospital and the community health center (CHC) was commonly reported. About 67 percent of Andkhoy cluster mothers knew at least two or more danger signs during pregnancy and 70 percent knew two or more danger signs during delivery.
2. Many community members attributed this knowledge to their own experience as well as education they received from the health facility staff - all pregnant mothers attending antenatal care sessions receive information on danger signs as part of their birth planning education. The male and female outreach workers (who are now no longer part of the new MOH facility staff) used to educate family members during home visits.

Gaps:

The knowledge of danger signs was poor in other districts of Jawzjan. Only 42 percent of mothers (KPC November 2003) were able to identify two or more danger signs and only 29 percent identified two or more danger signs during the postpartum period. While seeking emergency care from doctors working in provincial hospital in Shiberghan was commonly reported, many sought help from religious leaders/mullahs as well. Lack of family members' knowledge about danger signs, delayed/inappropriate decision making and lack of money were consistently reported by many MOH facility staff as factors associated with delays to access emergency obstetric care/skilled workers.

Client counseling and education approach used in Andkhoy cluster to teach danger signs, lacks uniform messages, IEC material and an overall information package. The health facility staff use hand made drawings and other related material that illustrate danger signs to provide information to the pregnant mothers.

It is also evident that husbands and other decision makers of the families are not always during the health education sessions. Usually health education is provided to the mother at the facility, which helps raise a pregnant mother's knowledge but does not necessarily promote prompt referral in case of need. This is because family members and decision makers lack information and may not be able to provide the appropriate support to a mother who has obstetric complications.

g. Malaria prophylaxis

In areas of endemic transmission, malaria in pregnancy is associated with severe maternal anemia and low birth weight babies. Malaria is not an endemic disease in most districts of Jawzjan⁸ except Darzaab, Qush tepa, Khuja du koh, and some of Shiberghan's remote villages. The MOH, with the help of HNI, implements social marketing strategies to introduce insecticide bed-nets.

Malaria is included in disease surveillance and HNI helped the MOH to establish a laboratory in the provincial health office, Aqcha and Andkhoy district hospitals. Save the Children UK also trained one laboratory technician in Darzaab CHC.

There is no shortage of anti-malaria drugs. The MOH receives regular supplies from Health Net International, UNICEF, WHO and ICRC.

Gaps:

There needs to be increased efforts for active surveillance of malaria in malaria zones. Hospitals/facilities only screen suspected malaria cases and not all patients suffering from fever. ANC services do not integrate screening of pregnant mothers for Malaria. The BPSH does not clearly mention/include malaria prophylaxis treatment for pregnant women.

The KPC survey shows that only 44 percent of mothers in other districts of Jawzjan reported that they and their children slept under an impregnated bednet. Very few mothers reported that their bednets had been re-impregnated.

4.1.2. Labor and delivery

a. Presence of Skilled birth attendants

The majority of pregnancies will proceed without difficulties, about 15 percent of all pregnant women will develop life-threatening complications requiring non-surgical obstetric care and 5 percent surgical interventions. It is not always possible to forecast which pregnancy can be at risk. It is therefore important for skilled birth attendants to assist all deliveries because they can, if the need arises, provide basic emergency obstetric care, rehabilitate a patient requiring referral and refer them on time to the right place⁹.

⁸ AIMS-WHO, Afghanistan

⁹ Quoted from the KPC survey, Andkhoy cluster, January 2003

The KPC surveys (2003), FDGs with communities and discussions with the MOH staff indicated that:

1. In both the Andkhoy cluster and other districts of Jawzjan most mothers delivered at home assisted by the TBAs/dayas, who were not always trained. TTBA's attended about 60 percent of deliveries in Andkhoy cluster.
2. TTBA's training emphasized most aspects of clean delivery including
 - clean hands;
 - clean surface to cut the cord;
 - use of a clean razor and string to cut and tie the cord;
 - danger signs;
 - referral of complicated cases; and
 - postnatal care and newborn care (breastfeeding, cord care, immunization).
3. The rate of use of clean birth kits for deliveries assisted by trained birth attendants was very high.
4. The use of a new razor blade to cut the cord was very common in all districts of Jawzjan. This is mainly due to TBA's own experience and beliefs and partly due to TBA training conducted by CDI and Save the Children/UK in some districts of Jawzjan. However there is no data that measures the tying of the cord with a clean string and subsequent clean cord care.

Gaps:

Skilled birth attendants such as female doctors, nurses and midwives assisted only 13 percent¹⁰ of delivering mothers in Andkhoy cluster and 28 percent¹¹ in other districts of Jawzjan. Home delivery has been practiced for many years as a tradition. The lack of skilled birth attendants, lack of delivery facilities in the local clinics, lack of money and transportation are all barriers that prevent accessing assistance from the skilled birth attendants.

Untrained birth attendants assist about 21 percent of delivering mothers living in Andkhoy cluster. This situation is worse in other districts of Jawzjan where untrained TBAs and relatives assist 65 percent of deliveries.

No TTBA's ever received training on basic EmOC and therefore are unable to provide first aid to women with obstetric complications such as postpartum hemorrhage (PPH).

c. Immediate Newborn care after delivery

Immediate newborn care includes the following aspects:

- 1) immediate drying, wrapping and warming;
- 2) delaying bathing;
- 3) immediate and exclusive breastfeeding;
- 4) resuscitating newborns with birth asphyxia.

¹⁰ KPC survey, Andkhoy cluster, January 2003

¹¹ KPC survey, Jawzjan, November 2003

The KPC surveys and FGDs revealed the following practices among communities living in Jawzjan province.

1. Unlike in other districts of Jawzjan, in Andkhoy cluster, TTBAAs cut and tie the cord soon after the delivery of the baby and usually they use a new razor. Many women who had recently delivered had heard about and used clean birth kits.
2. Assistants delayed bathing the newborn in 11 percent of the cases. In these cases caregivers believed that delaying bathing is important to prevent newborns from catching illnesses, or when newborns are blue or low birth weight (LBW).
3. Initiating breastfeeding within the first few hours is a common practice among communities living in Andkhoy cluster and in other districts of Jawzjan (76 percent and 61 percent respectively).

Gaps:

Save the Children's existing TBA training materials only cover newborn topics like cord care, eye care and immediate breastfeeding – it lacks the other aspects mentioned above.

Bathing newborn soon after delivery is a common practice as was indicated by the results of the KPC survey 2003 and FGDs. Many bathe the newborn as soon as it is born and then wrap it in a clean cloth and place it next to the mother.

In the Andkhoy cluster the existing TTBA wait for the placenta to deliver and delay tying of the umbilical cord¹². The cord is cut and the baby is left unattended while care is given to mother. TTBA must tie the cord immediately after cutting.

In Jawzjan, TBAs wait for the placenta to deliver and then cut and tie the cord. They believed that cutting the cord before the placenta is delivered makes the newborn weak and flaccid.

4.1.3. Immediate Postpartum contact and Essential Newborn Care

Immediate postpartum care is crucial within the first 24 hours and on the 2nd and 3rd days after delivery. This provides a great opportunity to

- a) examine the health of the delivered mother and provide her with vitamin A and iron supplementation;
- b) recognize danger signs and promote prompt referral;
- c) promote and support exclusive breastfeeding; and
- d) ensure clean cord care.

KPC surveys, FGDs with communities, discussions with MOH staff and review of secondary sources revealed the following practices among communities living in Jawzjan province:

1. The MOH staff understand the importance of a postpartum visit by trained health workers. They realize the mothers and babies could die during this time due to lack of appropriate care from the family.
2. The Andkhoy KPC survey 2003 results indicate that 84 percent of mothers were visited after delivery and many newborns were also examined. TTBAAs and skilled health workers conducted most postpartum visits (57 percent and 43 percent respectively). Nearly half of

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these mothers were visited at least three times. Most (75 percent) postpartum care (PPC) visits occurred within twenty-four hours after delivery.

3. Usually a TTBA's postnatal visit involved: assessing the general condition of the mother including signs of bleeding; cord examination and general health of the baby; and breastfeeding and its problems and giving information regarding BCG vaccine.
4. Many newborns were weighed within the first two weeks of delivery and nearly 93 percent of newborns received BCG vaccine.

Gaps:

Newborns are not weighed at birth and therefore there is no record of birth weight except at the hospital level. TTBA's are not trained to do this job nor do they have measuring scales.

Immediate postpartum care in the other districts of Jawzjan was very poor. Only 29 percent of mothers reported that their health was checked after their most recent delivery. These areas were devoid of trained TBAs, midwives and basic safe motherhood services and information.

The peripheral health facilities provided access to FP methods such as pills, injection and condoms but FP remained a low profile activity. Only 7 percent of mothers with children less than two years of age in Jawzjan province reported using a modern FP method. In Andkhoy cluster, the auxiliary midwives and TTBA's very recently started providing education on FP and the benefits of birth spacing to the communities.

4.2. Peripheral level facilities (EmOC)

This part of the report looks at the availability of antenatal, labor and delivery and postpartum care services at the peripheral health facilities. Peripheral health facilities must include one to six of eight EmOC functions described on page 2 above. Surgery or cesarean section and blood transfusions must be available at the district or provincial hospitals.

4.2.1. Pregnancy - Antenatal services

Since 1995 Save the Children has helped the MOH to implement primary health care (PHC) including safe motherhood services in Andkhoy. The antenatal coverage is excellent in Andkhoy cluster. Due to the fact that the skilled health workers, especially females declined to work in the rural areas due to insecurity, Save the Children and MOH staff trained local literate women as MCH workers to provide basic MCH services through basic health centers (BHCs) located in the rural districts. The results of the Andkhoy KPC survey 2003 reveal that 89 percent of pregnant mothers sought antenatal care during their last pregnancy and of these 96 percent sought ANC at the MOH health facilities with 70 percent attending at least three times. In April 2004, Save the Children partnered with the MOH to implement the basic package of health services (BPHS). As a part of this the MCH workers were recruited as midwives, who will now receive an 18-month midwifery training in Shiberghan hospital and will return to continue to provide safe motherhood services. In their absence the CS-19 MCH promoters and other trained midwives will provide antenatal services. The antenatal care services include:

- Head to toe examination of pregnant mothers including a check for anemia, blood pressure, edema, weight, fetal heart sounds and fundal height.
- Provision of Iron and folic acid tablets

- TT vaccination with a target to ensure that pregnant mothers have at least two doses.
- Education on birth planning/preparedness
- Screening pregnant mothers for risk factors
- Referral of cases with obstetric complications such as antepartum hemorrhage, miscarriage/abortion, pre-eclampsia, eclampsia and abnormal presentation to Andkhoy district hospital.
- Referral of pregnant mothers with fever to a physician working in the facility.

The midwives are trained to recognize antepartum hemorrhage, complications of abortion, pregnancy induced hypertension/pre-eclampsia, eclampsia, fever and Infection and abnormal presentations.

Gaps:

The results of KPC survey November 2003 conducted in other districts of Jawzjan reveal that ANC coverage is poor with only 56 percent seeing a health worker at the MOH health facility during their pregnancy. MOH facilities are the only places where ANC services are provided, if a trained female health worker exists, as a part of the BPHS.

None of the health facilities in Jawzjan were equipped to carry out urine tests or use Magnesium sulphate ($MgSO_4$) to manage severe pre-eclampsia and/or eclampsia cases.

TT vaccination was carried out regularly but most of the peripheral facilities (excluding Andkhoy cluster) either did not have the refrigerator for vaccines or they had malfunctioning refrigerators. Lack of female vaccinators prevented many women from getting TT vaccinations.

Health workers were not trained, equipped, or supplied to manage obstetric complications. This made the peripheral health facilities ineffective in providing life saving measures and at carrying out manual procedures for stabilizing pregnant mothers with complications before referral to the higher level facility.

4.2.2. Labor and delivery care

In Andkhoy cluster, the rural health facilities do not provide labor and delivery care services nor do they have appropriate space or equipment. Most deliveries occur at home as mentioned above and auxiliary midwives, doctors, nurses and a trained midwife attend only a few.

Save the Children is making efforts to recruit and train midwives for most peripheral health facilities between September 2004 to February 2006 CS-19 MCH promoters and SC/US's trained midwives will continue to encourage all registered pregnant mothers to identify their trained birth attendants and bring them to the health facility for a three-day training on clean delivery. During these training sessions, the auxiliary midwife also provides clean birth kits to the pregnant mother and her trained birth attendant. The health facilities in the Andkhoy cluster maintain accurate records showing the total number of deliveries every month, types of birth attendants and number of mothers who were referred. This information was generally lacking in other districts of Jawzjan. A checklist of health workers' (working in the peripheral facilities) basic EmOC skills and peripheral facility services/facilities is listed below.

Basic EmOC Interventions	Skills present
Availability and administration of antibiotics	✓
Availability and administration of Oxytocin	✓
Availability and administration of anticonvulsants/antihypertensives/sedatives for eclampsia/pre-eclampsia (state type-MgSo4 rec)	×
Perform manual removal of placenta	×
Perform removal of retained products-Manual Vacuum Aspiration (MVA) kit	×
Perform assisted vaginal delivery (with forceps or by vacuum extraction)	×
Perform External and internal bi-manual compression of uterus (with observation of aseptic techniques)	×
Management of asphyxia (Newborn Resuscitation, Adult resuscitation)	✓
Refer patients promptly to higher level for further management of complications.	✓
24/7 service availability	×
Transport and communication links to nearest referral facility	×
Documentation of obstetric cases managed effectively at peripheral facility (by type and treatment given) not requiring referral for further management	×

Four of the six signal/essential functions (as described on page 2) were available in the visited peripheral health facilities in Andkhoy cluster and in only a few other districts in Jawzjan.

Gaps:

Due in part to war and insecurity there had been a severe shortage of skilled health workers, especially females in the area. The situation is very poor in other districts of Jawzjan where access to trained birth attendants and skilled health providers is negligible.

A few privately practicing midwives are occasionally utilized in homes and sometimes in the facilities. This practice is allowed by the MOH. Most facilities lack labor and delivery care services and do not have appropriate space or equipment. In a few cases the doctor's examination table was utilized for delivery and in another, midwives used a set of their own personal items. Lack of water, toilets, delivery room, privacy¹³ () and equipment makes the peripheral health facilities unable to deliver quality services.

¹³ Facilities had either no windows or the other extreme of no curtains and even in some cases the room that was used was situated at the front of the premises near to the road.

Lack of transport, poor communication links with referral hospitals and limited hours of service delivery (most health facilities only operate for five hours 8am to 1pm) seriously impede the facilities' ability to have increased coverage for EmOC services.

The skilled providers (midwives and nurses) are not familiar with the use of partograph and active management of the 3rd stage of labor (with Oxytocin IM and IV, controlled cord traction and uterine massage) to prevent PPH.

4.2.3. Immediate Postpartum (PPC) and PPC at six weeks

The services provided during the immediate postpartum care visits in Andkhoy cluster and other districts of Jawzjan are listed below.

Immediate postpartum care	Andkhoy	Jawzjan/other
Postpartum visit by skilled birth attendant within first 72 hours after delivery (0-6-24hrs, 2nd and 3rd days)	✗	✗
Postpartum visit by TBAs within first 72 hours after delivery (0-6-24hrs, 2nd and 3rd days)	✓	✗
Promotion of immediate and exclusive breastfeeding	✓	✗
Immunizations required by local policy at birth: BCG, OPV.	✓	✓
Immunizations required by local policy at birth: HB1, Vit. K	✗	✗
Clean cord care	✓	✓
Prophylactic eye care (newborn)	✗	✗
Vitamin A supplementation (mother)	✓	✗
<u>Mother and Newborn:</u> Danger signs recognition and referral for care if necessary	✓	✗

Between 1995 and 2003, the primary health care program in Andkhoy cluster emphasized PPC through TTBA's and occasional supervision and home visits by skilled workers. The auxiliary midwife (former MCH worker) provided a three-day training to both the mother and her birth attendant on clean birth during which the importance of postpartum care is emphasized.

TTBA's provided PPC mostly within two to seven days after delivery. MOH staff mentioned that many newborns are brought within a few hours to two days after delivery for BCG/OPV vaccination – this high coverage of BCG vaccine at birth indicates a very good immediate postnatal contact. Clean cord care and vitamin A supplementation are a crucial part of the PPC visit.

Gaps:

MOH staff understand the importance of immediate postpartum care by skilled providers but rarely provide it. Lack of transportation and insecurity are some of the reasons why female skilled workers such as auxiliary midwives do not visit delivered mothers in their homes. Long distances to health facilities and lack of transportation also prohibited mothers and newborns from receiving facility-based postpartum care by skilled workers. Except in the Andkhoy cluster, generally the MOH staff's knowledge of PPC is limited to mother's abdominal examination and care of the newborn's cord.

The coverage of postpartum care by TTBAAs to both the mother and the newborn in other districts of Jawzjan is very poor. This is because there are so few TTBAAs and the health workers have only just started implementing safe motherhood services. Generally, the quality of immediate PPC provided by TTBAAs is unknown and therefore there is a need to assess their knowledge and to observe how they provide PPC.

The strategy of providing postpartum care at six weeks is generally lacking in all the districts of Jawzjan. Consequently a timely opportunity to promote FP/child spacing, exclusive breastfeeding and childhood immunization is lost.

4.3. District Hospital level (CEmOC) or EmOC

This section presents the findings that are related to EmOC services, desirable at the district hospital facility level. All eight EmOC functions (see page 2) must be available at the district or provincial hospitals. There are three hospitals in Jawzjan province, one district hospital in Andkhoy town, one district hospital in Aqcha and one provincial hospital in Shiberghan city.

4.3.1. Pregnancy care – Antenatal care services

In the Andkhoy cluster of villages the antenatal care services are provided at the MCH clinic (now called CHC) located within the premises of the district hospital. One female doctor, a female nurse and one auxiliary midwife (former MCH worker) conduct antenatal care sessions in a similar fashion as described under the peripheral level health facilities section (see page 14) . The main antenatal care services provided include:

- Examination of pregnant mothers including a check for anemia, blood pressure, edema, weight, fetal heart sounds and fundal height.
- Provision of Iron and folic acid tablets
- TT vaccination with a target to ensure that pregnant mothers have at least two doses.
- Screening of pregnant mothers for risk factors
- Referral to district hospital cases with obstetric complications such as antepartum hemorrhage, miscarriage/abortion, pre-eclampsia, eclampsia and abnormal presentation.
- Management of mothers with fever.
- Urine analysis using hospital laboratory (for few selected cases)

Aqcha district hospital and Shiberghan provincial hospital also provide antenatal care services to their few registered clients through their MCH departments.

Gaps:

Unlike in Andkhoy district hospitals, birth planning education and danger signs approach are not integrated as an essential service package at the Aqcha district and Shiberghan provincial hospitals.

The Risk-approach screens pregnant women who need most attention and they are advised to return more frequently. Other pregnant women, who don't have any risk signs, are advised to return for the next ANC visit two weeks prior to the expected date of delivery.

Except for the Shiberghan provincial hospital, facilities to screen, test and treat STDs including syphilis is lacking.

4.3.2. Labor and Delivery services

Availability of surgical facilities:

Both districts hospitals in Andkhoy and Aqcha have one operation theater. The provincial hospital in Shiberghan has two. There is at least one room for an autoclave where all equipment is sterilized. There is at least one delivery room in each of these hospitals with at least one delivery table. There are two to three rooms where women either rest for two to three hours after a normal delivery or six to seven days after a caesarian section. The provincial hospital in Shiberghan was renovated and equipped by the Turkish government four years back and recently by ICRC. The latter contributed to painting of the hospital, installation of piped water, construction of several basins for hand washing and construction of several washrooms. ICRC also renovated the gyn/obstetric wards, operation-theater, donated several sets of surgery kits and trained several midwives for short periods of time.

There is one anesthesiologist in each district hospital and one in the provincial hospital. There is a general surgeon in Andkhoy and Aqcha and a general surgeon and a ob/gyn in the provincial hospital. There are two female nurses in Andkhoy, one in Aqcha and two in Shiberghan.

The provincial hospital and both district hospitals have adequate anesthetic equipment including an anesthetic machine, laryngoscope, ambo bags, tracheal tube, tracheal tube tamp, airway equipments, oxygen cylinder and masks. Aqcha district hospital lacks airway equipment, oxygen cylinders and masks. Andkhoy district hospital and Shiberghan provincial hospital has adequate resuscitation equipment such as mechanical respirator, suction tubes and machine and intubation tubes. Aqcha lacks this facility.

Only Aqcha district hospital has one caesarian-section kit, one hysterectomy kit and one laprotomy kit. Both Andkhoy district and Shiberghan provincial hospitals do C-section when required and use other surgical instruments. They lack C-section, laprotomy and hysterectomy kits. Surgical equipments are available in all the three district hospitals. The Andkhoy district and the provincial hospitals have one MVA/D&C kit. Only Shiberghan provincial hospital has a complete set of delivery forceps. Vacuum extractors are lacking in all.

Both the Shiberghan provincial and Andkhoy district hospitals have blood screening and on the spot transfusion facility. Blood storage is only present in the provincial hospital. Most of the time donor's blood is matched and transfused immediately.

Both district hospitals have at least one vehicle/ambulance (two in Andkhoy district hospital) but no telephones or other communication means. Most of the time the ambulances are used to refer obstetric cases to the provincial hospitals.

ICRC's contribution to infection prevention in the Shiberghan hospital is commendable and this is noted by:

- A presence of a functional incinerator
- Running water and soap in each ward.
- A functional autoclave and a generator
- Careful handling of drums containing sterilized gauze and cotton
- Careful protection of sterilized equipment for dressing and for surgery.
- A system that provides sterilized gowns and gloves
- Adequate use of disinfectant for securing waste, cleaning ward floors, footpads, washrooms.

In summary, the following EmOC functions are available at each of the visited hospitals:

EmOC functions	Andkhoy	Aqcha	Jawzjan other
Antibiotics (intravenous or by injection)	✓	✓	✓
Oxytocic Drugs (IV, IM)	✓	✓	✓
Anticonvulsants (IV, IM)	✓	✓	✓
Manual Removal of retained placenta	+ - ¹⁴	✓	✓
Removal of retained products (e.g. Using MVA kit)	✗	+ -	✓
Assisted vaginal delivery (vacuum extraction, forceps delivery)	✓ Forceps	✓ Forceps	✓ Forceps
Blood Transfusion	✓	✓	✓
Blood Storage	✗	✗	✓
Surgery (Caesarian Section)	✓	+ -	✓
Total EmOC functions	6.5	7	8

Manual removal of placenta is done in the provincial hospital in Shiberghan where there is a trained obstetrician. In Andkhoy district hospital one doctor who has several years of experience working with an obstetrician in the past does it, when she is available. The knowledge and skills of MOH staff regarding active management of the 3rd stage of labor (with Oxytocin IM and IV, controlled cord traction and uterine massage) to prevent PPH is good.

All hospitals ran 24 hours a day seven days a week. Following are types of emergency obstetric care provided since January 2004:

¹⁴ Some providers able to perform.

Types of EmOC services	Andkhoy	Aqcha	Provincial
Number of surgery (Cesarean section)	34	11	41
Number of cases where placenta products were removed using MVA kits	0	12	10
Number of cases where placenta was removed bi-manually	4	10	12
Number of complicated cases referred	10	4	2
Total	48	37	65

Gaps:

Aqcha district hospital lacked airway equipment, oxygen cylinder and masks, respirator, suction tubes and machine and intubation tubes. All hospitals lacked vacuum extractors and had inadequate numbers of delivery forceps (some need replacement). The district hospitals lacked a blood storage facility due to lack of refrigerators and other blood transfusion equipment.

The District hospitals lacked equipment as well as skills for the removal of retained products (e.g. using MVA kit). None of the hospitals did use a partograph to monitor delivery. The district hospitals did not follow infection control procedures and this was evident from:

- Inadequate use of chlorine/antiseptic- lack of bowls containing antiseptics/ chlorine for keeping sterilized dressing equipment.
- Misappropriate handling of dressing drums containing sterilized cotton and gauze.
- Inadequate use of rubbish bins – absence of incinerators
- Misuse of surgical gowns and gloves – staff move around in surgical gowns and gloves in and out of operation theater
- Inadequate dusting and cleaning. Floors covered with dust and footprints.
- Inadequate cleaning of bed sheets and covers
- Inadequate water supply and use of soap

Lack of telephones or radios in the district hospitals contributed to poor communication links between the district and provincial hospitals.

4.3.3. Immediate and later Post partum (PNC) care contact and ENC

In all hospitals delivered mothers are kept in the labor room for an hour for observation – during this time mothers were given vaginal pads, newborns were weighed, bathed and provided to the mother for breastfeeding and registration was carried out. The later postnatal care in the wards included observation of the mother for involution, bleeding and establishment of breastfeeding and observation of the general health of the baby. The mothers and babies stayed in hospital from between 3 to 6 hours in the case of a normal delivery and from 3 days to 6 days in the case of assisted or surgical delivery. During their stay in the hospital the newborn was provided BCG and polio vaccines.

at the time of discharge the mother and newborn are usually advised to come back after a week. The provision of later postnatal service is dependant on the mother's/family's choice for returning for a check-up. Generally hospital staff did not actively promote a sixth week postpartum visit. .

Gaps:

During discussions with the MOH staff it was found that their knowledge and skills regarding breastfeeding counseling was inadequate.

The time mothers and newborns spent in the hospital after a normal delivery was too short to provide quality postpartum care. Many maternal and newborn complications arise within the first three days after delivery.

There was no feedback system between the provincial/district hospitals and the peripheral facilities and therefore no postpartum care actively extended through peripheral staff, unless the mothers or the newborns faced complications and attended the health facilities on their own. Postpartum care at six weeks was generally absent.

4.3.4. Essential drugs and supplies

The district hospital in Andkhoy receives essential drugs from the provincial health office located in Shiberghan. Previously it was provided by WHO, UNICEF, MOH and Save the Children USA. The district hospital in Aqcha receives essential drugs provided by the REACH program/Save the Children UK on a monthly basis. The provincial hospital in Shiberghan receives essential drugs from ICRC, MOH, WHO and UNICEF on a monthly basis. The condition of the drugstores in all hospitals was good, the room temperature was satisfactory, each drug or medical supply items was placed in shelves neatly and the logbooks were maintained regularly.

Gaps:

In Andkhoy district hospital occasional stock out of essential drugs for OPD and IPD were reported. It is not clear whether the Turkish government that is supporting the hospital supplied essential drugs.

4.3.5. Monitoring and Supervision

In Andkhoy hospital the work of the surgeon and the anesthesiologist were supervised by the hospital director. The nurses were supervised by a surgeon and a head nurse. In the provincial hospital the medical super attendant (MS). supervised surgeons, ob/gyn and anesthesiologists and a surgeon and head nurse supervised the nurses. . The supervision included checking the operation room/equipment, sterilization room/equipment, operation registers, roster, bed sheets etc.

Gaps:

There was no standard supervisory checklist. Frequent stock-out of essential drugs were noted in Andkhoy district hospital.

4.3.6. Twenty-four hour - seven days/week service (24/7)

The emergency unit of all the three hospitals operated 24 hrs a day, 7 days a week. Each hospital had a roster that showed two doctors, two nurses and two cleaners on duty. Each hospital had an ambulance (Aqcha had a rented car).

Gaps:

The hospital staff in Andkhoy and Shiberghan received token salaries that contributed to demotivation.

There was a lack of funds for vehicle maintenance, petrol, oil and lubricants. Most of the time ambulances were off the roads. Aqcha had rented a vehicle and its driver refused to bring patients from remote villages that have bad roads.

4.4. Linkages between the levels of HHC

4.4.1. Household and Peripheral health facilities

One important link between the communities and the peripheral health facilities was the availability of a trained TBAs – (TTBAs). TTBAs belonged to the villages they were serving. When the health workers from the local MOH clinics had trained the TTBAs there was a close relationship between the communities and the health facilities. For example in Andkhoy cluster TTBAs are responsible to: report all deliveries and register births at the local facility; provide feedback on the status of the delivered mother and newborn; ensure that the newborns receive BCG vaccines; register newborns at the growth monitoring clinics; and ensure mothers with obstetric complications receive skilled care. TTBAs were regularly supported by health staff in the form of regular feedback on their work and refresher courses. This type of meaningful link and working relationship between the TTBAs or any other grass root health worker and the facility staff was generally lacking in other districts of Jawzjan.

Another important link is the local auxiliary midwife – most of whom are residents of the area where they work. Where they were resident in the community auxiliary midwives were familiar with the community norms, traditions and social structure. In Andkhoy cluster the auxiliary midwives were linked to their communities through their ties with the TTBAs, outreach activities/services and home-visits. These links were developing in other districts of Jawzjan,

Where community health committees¹⁵ (CHCs) were formed, trained and supported, communities had stronger links with the health facility staff. This was more evident in Andkhoy cluster where CHCs encouraged health promotion and social mobilization activities in the village for increased utilization of the services. –They had played a key role in assisting NIDs campaigns, linking ANC and EPI clients with facilities and supporting TTBAs in the area. An encouraging recent development in Andkhoy cluster was the establishment of female health committees. While the MOH also used community elders in other districts of Jawzjan, these districts lacked formal CHCs and therefore an important strategy for linking communities with the health facilities.

4.4.2. Peripheral health facilities and Hospital

The peripheral facilities were dependant on the hospitals to provide them medical supplies equipment and trainings. They were also linked to them through the HIS reporting, monitoring and

¹⁵ Members are schoolteachers, community elders and health facility staff

supervision system. these linkages are stronger in Andkhoy cluster where the district hospital through its EPI and PHC supervisors played a key role in supporting the peripheral health facilities. Links between peripheral facilities and hospitals in other districts of Jawzjan were developing.

All peripheral health facilities lacked telephones, ambulances and other means of communication which they were unable to inform the hospital regarding emergency referral. Had hospitals known in advance the condition of the mother or newborn that had been referred they would be better prepared to meet emergency needs.

Hospitals worked independently and had limited linkages with either the peripheral facilities or the other private facilities within the district or province. The district and provincial hospitals did not have a feedback system with the peripheral health facilities to inform about the status of the mothers and newborns referred to them nor did they refer back cases to the peripheral health facilities for continued support and follow-up. Most hospitals advised families to bring mothers or newborn for the follow up session and many clients do not return due to time constraints, lack of money and transportation.

Most hospitals had an ambulance service, but its role was not clearly defined. They were mostly used to bring mothers with complications to deliver at the hospitals. Transportation of mothers and newborns back to their homes was discouraged due to limited funds.

5. Discussions and Conclusions

5.1. Household/Community level:

5.1.1. Access to micronutrients (Iron, folate, Vitamin A and Iodine)

Coverage of iron and folic acid supplementation was good where Save the Children USA and other NGOs had supported the MOH to provide these micronutrients as part of the ANC services. Knowledge regarding foods that are rich in iron and about iron tablets was poor in villages with an inadequate peripheral health delivery system. Providing these important nutrients through ANC clinics and TTBA's and counseling and educating pregnant mothers so that they understand why consuming these nutrients is important are proven strategies to enhance access, demand and utilization. Lessons learned from the Andkhoy cluster should be replicated in other parts of Jawzjan.

Both the high coverage of BCG vaccine at birth and immediate postpartum contacts demonstrate that contact opportunities already exist in which postpartum vitamin A supplementation could be integrated. This is especially true for the Andkhoy cluster where the peripheral health delivery health system is more advanced.

It is encouraging to note that UNICEF and the MOH are making efforts to market iodized salt in Jawzjan. Save the Children USA and UK can compliment this effort by utilizing the peripheral health delivery system and community mobilization strategies. Messages can be integrated within antenatal birth planning/ANC client counseling package and outreach activities. CHWs, CHC members, midwives and CS-19 MCH promoters could play a crucial role in promoting the use of iodized salt.

5.1.2. TT vaccine

Coverage of two doses of TT vaccine among pregnant women in Andkhoy cluster is high and this is due to high attendance of pregnant women at the ANC clinics, integration of TT vaccine within ANC services, community education and motivation activities, effective use of community networks and outreach activities and most importantly recruiting and training female vaccinators. These are all very important strategies that are still developing in other districts of Jawzjan as well as in some remote villages in the Andkhoy cluster.

5.1.3. Birth planning and knowledge of danger signs

Birth planning is the most important component of the household to hospital continuum of care. The elements that are crucial for the birth planning are:

- a) attending antenatal care sessions regularly;
- b) adopting good nutrition habits and rest;
- c) ability to recognize danger signs and take immediate actions;
- d) identifying place of delivery;
- e) identifying skilled birth attendants (or TTBAAs);
- f) saving money for emergencies;
- g) arranging transportation; and
- h) identifying blood donors.

It is important that the birth preparedness/planning strategy is integrated within the whole service package and implemented through community agents and health care providers. This will ensure that families are proactive in making their birth plans and that women with obstetric complications access EOC service in a timely manner. Implementation of this strategy is crucial for the Jawzjan area where many villages lack access to skilled workers and good roads and transportation is unavailable on a daily basis.

Generally communities lack the birth-planning concept and to date very little has been done to integrate this strategy within the existing safe motherhood services. Save the Children US and UK are developing a community based health delivery system that calls for enhanced community participation and community consultation at all levels of the CS-19 project development. The birth-planning strategy should be an integral part of the community based health delivery system.

A MSH/REACH/USAID consultant is working with the MOH and NGOs to put together birth-planning strategies, behavior change materials and activities. Save the Children can carry out experience based advocacy efforts to influence this national effort and share lessons learned from its primary health care programs in the Afghan refugee camps in Pakistan and Andkhoy cluster. In addition, CS-19 staff identified the communities' positive birth preparedness practices. This learning will further help in designing an appropriate local birth planning strategy.

5.1.4. Danger signs approach

The BPHS is a set of interventions that must be made available to the communities. However this guideline does not have details on how to implement these interventions. Where implemented the antenatal care services were based on the risk approach as described in the findings section above. This approach encourages pregnant women classified as high risk to attend ANC sessions more frequently and inadvertently discourages frequent visits by all other pregnant women, who are also at risk of developing complications at any time during their pregnancy. There is an immediate need to educate ANC clients and their family members about danger signs and the importance of taking prompt and immediate action. This requires a series of training for the MOH staff and revision of

existing/developing new MNC guidelines and education materials. Education materials from the Afghan refugee primary health care program could be reviewed and adapted to suit local needs.

Traditionally pregnant mothers have always been targeted by health education activities. Even KPC surveys show that this effort has increased their knowledge - but has this actually helped them to seek prompt care outside home when complications develop? It is important to develop a family oriented approach to raise the knowledge among key decision makers/family members. This will help ensure that time is not wasted before seeking outside care, once complications are recognized.

5.1.5. Malaria Prophylaxis

Malaria control activities have developed considerably in the past few years with the help of HNI, WHO and MOH, however, the MOH staff need to carry out more proactive screening of pregnant women with fevers to exclude malaria and to provide radical treatment when they have it. Malaria prophylaxis has to be introduced and promoted especially in the malaria endemic areas. Integrating malaria prophylaxis within ANC services is an important strategy. Promoting the use of impregnated bed-nets should be integrated within the birth planning strategy.

5.1.5. Access to skilled health workers/birth attendants:

Save the Children USA's efforts to train community-based midwives, through the REACH program will considerably increase access to skilled health workers. These midwives were selected with the help of community elders and the areas MOH staff. Once these women complete their 18-month training course and are certified they will return to work in the peripheral health facilities, where they will provide antenatal, safe delivery and postpartum care. They will also have a role in the promotion of the danger signs approach and birth planning. The existing network of CHC members, CHWs and TTBAAs can be utilized to link pregnant and delivering women to midwives.

5.1.6. Immediate postpartum care and postpartum care at six weeks:

The findings reveal that immediate postpartum contact is excellent in the Andkhoy cluster because the antenatal coverage is high and registered mothers are easy to locate. The established primary health care program is well connected with community networks of CHC and TTBAAs. Such a system needs to be developed in other districts of Jawzjan as this provides a great opportunity to improve the quality of maternal and newborn care and link clients and TTBAAs with the midwife/skilled providers. Save the Children USA and UK are improving the health delivery system at the district and community levels. The lessons learned from the Andkhoy cluster could be replicated in other districts of Jawzjan.

Waiting for the placenta to deliver, inadequate wrapping of the newborn and bathing newborns soon after delivery are factors leading to hypothermia and death of a newborn. The existing training on immediate postpartum care lacks important elements such as how to deal with birth asphyxia and drying/warming. These must be included in addition to those that already exist within the PPC training module (early initiation of breastfeeding, cord care, eye care, postpartum vitamin A to mother). The MOH staff, CHWs and TTBAAs need to understand the difference between the immediate postpartum care and postpartum care at six weeks. The PPC training module must emphasize/highlight that PPC at six weeks provides an excellent opportunity to promote FP and exclusive breastfeeding practices.

5.2. Peripheral Health Facility level:

5.2.1. Access to basic maternal and newborn care services

Access to maternal and newborn care services remains poor in most parts of Jawzjan. . All women of childbearing age should have access to antenatal care (with iron, folic acid and postpartum vitamin A supplementation, information on iodized salt and TT vaccine) safe labor and delivery care and postpartum care. Community networks of CHCs, CHWs and TTBAAs must play an active role if this is to eventuate. For the other districts of Jawzjan and in areas that are located in remote parts of the Andkhoy cluster, the community networks active participation is vital.

The USAID funded REACH program, initiated in March 2004 by Save the Children USA and UK aims to assist the MOH develop its health systems at the district levels in the Jawzjan province. To date doctors, nurses, vaccinators and auxiliary midwives have been recruited and placed in all the peripheral facilities. Auxiliary midwives¹⁶ are responsible for providing basic MCH services including antenatal care (including TT vaccines, iron and folic acid tablets), postnatal care (including postpartum vitamin A) and clean deliveries (use of clean birth kits). The Cold chain is being established in all peripheral facilities and at least for the next two years there should be no stock out of essential drugs and supplies.

Recruitment of CHWs (both male and female) has started in villages located in areas, where communities cannot access health services and where services will be provided through health posts.

Save the Children US has recruited the CS-19 MCH promoters and placed them within each basic health center (BHC). There, they will train and support midwives and CHWs and ensure implementation of community awareness and health education activities. The CS-19 MCH promoters and the CHWs will educate, inform and refer the mothers for TT vaccination. This should ensure that most women will have access to basic maternal and newborn care and EmOC services in other districts of Jawzjan, like in the Andkhoy cluster.

5.2.2. Labor and delivery services

The existing peripheral health facilities cannot currently provide labor and delivery services nor can they manage obstetric complications. This is due to a lack of midwives/skilled birth attendants, lack of equipment and space. These factors make the peripheral health facilities ineffective in providing life saving measures and manual procedures for complications in order to stabilize mother's condition, before referral to the higher level facility.

One important development that Save the Children USA initiated is the midwifery training in Jawzjan. The aim of this initiative is to provide 18-month midwifery courses to community based literate women and post them at the peripheral health facilities. This will ensure availability of skilled health workers to attend deliveries. The EmOC functions will be available in all the upgraded peripheral facilities¹⁷ once the trained midwives return to work. The trained midwives maybe able to integrate more than the minimum of six EmOC functions.

Ideally a trained midwife must be able to use a partograph to monitor labor and carry out active management of the 3rd stage of delivery i.e. giving oxytocin injection, carrying out controlled cord

¹⁶ Where there are no midwives, auxiliary midwives have been appointed. They will be replaced when midwives return from their 18-month training course.

¹⁷ . REACH/BPHS has provision to renovate the facilities.

traction and uterine massage to prevent PPH. She should be able to give antibiotics orally and intravenously remove pieces of placenta manually and resuscitate a newborn to correct birth asphyxia. However, a midwives ability to carry out these procedures depends upon the midwife's training and the MOH's policies. It is important to assess, discuss and prioritize basic EmOC functions that should be available at the peripheral level.

It is important to support the work of midwives. Acknowledgment of their efforts, performance, achievements and any challenges that they may have overcome is crucial. This can be done through sharing real life experiences of dealing with complex situations of maternal and newborn care in forums, gatherings and places of celebrations to promote integration and strengthen linkages of midwives with the communities.

5.2.3. Family planning services

Family planning services were available but not freely and were not marketed as a package. They are available as a routine service at peripheral facilities (with condoms, pills and injectables). However the opportunity of promoting FP during postpartum visits remains un-availed. Focus group discussions with community members and MOH health staffs revealed that there was limited discussion between married couples regarding birth spacing and FP. Many community members had misinformation related to FP. A more community oriented approach involving gaining consensus support and the confidence of religious leaders, and family decision makers is vital. An intervention which encourages and facilitates dialogue on FP/child spacing within married couples should be explored..

Promoting FP during postpartum care visits will require training of health facility staff and the TTBA's. To date, MOH staff and TTBA's have never received training on FP and the concept of promoting FP based on informed choice is very poorly understood.

5.3. District and Provincial Hospitals-level:

Both district hospitals can at least provide six of the eight EmOC functions. They have the structure and space to provide all eight functions if they establish a blood bank, receive essential anesthesia and surgery equipment and regular supplies of essential drugs. A complete assessment needs to be conducted to reflect the infrastructure, equipment and supply needs and other administrative, logistical and managerial issues that hinder the provision of services.

Both the district hospitals severely lack infection control measures making these hospitals undesirable places for childbirth and surgical cases. Trainings on infection control establishment of a system of supervision and accountability, ensuring adequate supplies of water and antiseptics and construction of incinerators for proper waste disposal should be prioritized. storage tanks should be constructed to ensure a regular supply of water to meet the hospitals water needs including infection control. While the infection control is satisfactory in the provincial hospital it would be beneficial to involve key hospital staff in related training and monitoring and supervision activities.

5.4. Linkages between Peripheral Health Facility and Hospitals

The linkage between the peripheral facilities and hospitals and again the hospital with peripheral facilities are not established. The peripheral facilities should be able to refer mothers and newborns to the hospitals and inform them in a timely manner of the coming emergency. This would allow essential preparations and response with timely service provision by the referral hospitals. On discharge of the mother or newborn, the continued care advised for home should be shared with the referring peripheral facility so that the mother and newborns care are followed up during home visits

and on subsequent visits to the peripheral facility. This would strengthen the service and community linkages. It would help establish communication channels providing avenues for support and mentorship of the peripheral providers. The section 4.4 on page 23 describes important linkages between communities and the peripheral health facility and hospitals. When developing a referral system these important linkages must be taken into account.

6. What else could be done (suggestions/recommendations)

6.1. Increase access to and utilization of EOC services including essential micronutrients such as iron, folic acid and iodine during pregnancy. Increase access to and utilization of postpartum vitamin A.

Recommended activities:

1. Integrate provision of iron and folic acid supplementation within ANC services. Provide these micronutrients to all pregnant women attending the ANC sessions or met during home visits by midwives or TTBAAs coupled with education on the importance of taking iron, folic acid and iodized salt.
2. Review and refine maternal nutrition education materials and approach. Train CHWs, TTBAAs, midwives and nurses on their use.
3. The CS-19 coordinator and BCC Officer must work with the MOH and UNICEF to enhance their social marketing efforts for iodized salt. Develop solid community awareness and education strategies. For example promote awareness through using the network of CHWs, TTBAAs, CHCs and midwives.
4. Establish links between midwives, CHWs and the existing TTBAAs. Together with the MOH staff and CHCs, map villages, identify clients for MNC services and implement community awareness and motivational activities.
5. Implement a Partnership Defined Quality (PDQ) in one pilot area to understand and improve the quality of MCH services from the community perspective and guide strategies for increasing use of these services

6.2. Increase coverage of at least two doses of TT vaccine among pregnant women.

Recommended activities:

1. Integrate provision of TT vaccine within ANC services. Provide TT vaccine during sick child visits, ANC visits and any other visits made to the health facilities.
2. Use community maps to trace and vaccinate pregnant women. Conduct community mobilization and education activities through CHWs, TTBAAs and CHC members.
3. Provide EPI training to female CHWs and where possible provide them with health education materials, cold boxes, TT vaccines and other EPI supplies.

6.3. Implement appropriate birth planning and community alarm and transportation strategies

Recommended activities:

1. Assist in the national effort to develop birth planning materials, strategies and concepts. CS-19 MNC officer and her MOH counterpart should have opportunities created for them to share their experiences.
2. Train MOH staff on the concept of birth planning. Provide birth-planning education to all pregnant women and their family members attending ANC sessions or met during home visits. Involve auxiliary midwives, midwives (where available), CS-19 MCH promoters, TTBAAs and CHWs in the community education effort.
3. Train MOH staff, especially the auxiliary midwives/midwives on the danger sign approach. Encourage all pregnant women to attend ANC at least once in each trimester. Ensure that danger sign education is included in the birth planning education package/activities.
4. Train CHC members on the concept of birth planning. Discuss and establish their role in this strategy. In one pilot area, develop and implement a community alarm and transportation system jointly with CHC members and MOH staff. Document the results by the end of CS-19's 3rd year.
5. Once the midwives return to their designated health facility – establish her links with CHC members, CHWs and TTBAAs. Train her on the concept of birth planning and support her in developing this role

6.4. Implement malaria prophylaxis and compliment existing effort for social marketing of insecticide impregnated bed nets.

Recommended activities:

1. Integrate malaria prophylaxis within antenatal care services in the areas where malaria is endemic.
2. The CS-19 coordinator, MNC and BCC Officers must work with the MOH and HNI to enhance their social marketing of impregnated bed-nets. Develop community awareness and education strategies. For example promote awareness through using the network of CHWs, TTBAAs, CHCs and midwives.

6.5. Increase access to good quality immediate postpartum care and postpartum care at six weeks.

Recommended activities:

1. Review and refine the existing MNC training module to incorporate essential postpartum maternal and newborn care elements. Pakistan SNL guidelines and materials could be reviewed as a part of this process. When developing newborn care package the following findings on immediate newborn household practices (reported in the FGDs) must be kept in mind:

- The practice of cutting and tying the cord soon after the baby is born (a beneficial practice)
 - Keeping the newborn away from the mother for two to three days after delivery in order to keep it safe from catching illness from the mother's milk (detrimental practice).
 - Delaying bathing for a couple of days (beneficial practice)
 - Immediate breast-feeding (beneficial practice)
 - Discarding colostrum especially in the other districts of Jawzjan (detrimental practice)
2. Ensure procurement of MNC health education materials with key postpartum care messages. Either use/adapt existing materials available in Afghanistan or adapt health education materials developed in Pakistan for the Afghan refugee primary health care program.
 3. Provide MNC training to the MOH facility staff, especially auxiliary midwives/midwives. The training session must also focus on immediate postpartum care and postpartum care at six weeks. Supplement this training with sessions on newborn care, maternal care, maternal postpartum vitamin A and iron supplementation, FP and exclusive breastfeeding. Provide similar but shorter trainings to CHWs and to the existing TTBAAs.
 4. Establish links between midwives, CHWs and the existing TTBAAs. Together with the MOH staff and CHCs, map villages, identify clients for PPC services and implement community awareness and motivation activities.
 5. Use MNC registers and logbooks to trace registered women and provide immediate PPC (through midwives, female CHWs and TTBAAs). Use immediate postpartum visits to motivate women and their families to attend PPC session at least at six weeks after the delivery. In addition, use the network of CHWs and existing TTBAAs to provide PPC at six week at homes.

6.6. Build the capacity of peripheral health facility staff, especially midwives to provide basic MNC services (antenatal care, EmOC)

Recommended activities:

1. Develop and implement a support mechanism for the trained midwife (once she returns to work at the peripheral health facility) to enhance her role in MNC. Supportive supervision, refresher courses and raising awareness in the communities regarding her role are some important strategies.
2. Based on the skills midwives gain from their 18-month training course – prioritize EOC and EmOC services that she should provide at the peripheral facility and community level.
3. Improve the environment in the health facility to ensure delivery of good quality EOC services six days a week and EmOC services 24 hours/seven days a week.
 - Ensure that supply of essential drugs (such as inj. oxytocin, anticonvulsants, IV fluids/or ORS) and other medical supplies is regular.

- Ensure adequate space, with privacy, running water and soap. There should be one room for midwives to carry out basic EOC services and a room for EmOC.
 - Approve and appreciate that midwives work through homes after official hours and in case of an emergency call.
4. Discuss the possibility of using Magnesium Sulphate(MgSO₄) for the treatment of pre-eclampsia cases. Train health facility staff, especially the midwife on its use. Refer cases of eclampsia to referral hospitals.

6.7 Improve Infection Control at peripheral health facilities and district hospitals

Recommended activities:

1. Provide a TOT course on infection control for MOH staff working at the peripheral health facilities. Conduct a separate course for the district hospitals staff.
2. Assist the MOH to develop a supervisory checklist and conduct monitoring and supervisory visits to ensure that good quality infection control is in place.
3. Provide information to PHO and Save the Children UK regarding the importance of installing incinerators at the district hospitals.

6.8. Develop and use a community based referral system. Establish an efficient referral and feedback system between the district and the provincial hospitals.

Recommended activities:

1. Develop a referral system that promotes:
 - a) linkage with communities through CHCs, CHWs and existing TTBA's and
 - b) timely referral of women with obstetric complications to midwives and/or district hospitals.
2. Develop and establish a referral and feedback system between the peripheral health facilities and the district hospitals.

ANNEX II

Focus Group Discussions

Focus Group Discussions to explore health issues identified during KPC survey - March 2004

1. Introduction:

A KPC survey conducted in September 2003 raised a lot of important issues that needed to be explored in order to better understand these issues and use this information to develop appropriate strategies for CS-19 interventions. These issues are listed as follows:

1. To explore in Andkhoy cluster, especially in remote villages and in other districts of Jawzjan, why women are not seeking ANC and PNC services and why most women are delivering their children at home instead of at a health facility.
2. To understand issues related to the very initial handling of the newborn baby, particularly related to bathing, skin-to-skin contact with the mother, and early initiation of breastfeeding.
3. To better understand health seeking behavior and home care for sick children especially explore why many mothers are decreasing the amount of fluids and food they provide to sick children and why so few mothers are providing ORS to treat childhood diarrhea.
4. Some mothers are waiting three or more days to seek care for ARI-related symptoms in their children, especially when these are some of the most commonly recognized danger signs. Are they using home remedies to treat ARI before they seek care outside? What are these home care remedies and when do they use them? Why are a few mothers taking their sick children to BHCs.
5. To explore with men and women, how FP decisions are being made by couples and the reasons why.
6. To explore why so few mothers have EPI cards for their children. Are there any cultural, economic, or systemic factors that might be leading to the low EPI coverage and discuss ways that the project can increase this coverage.

2. Methodology:

Participatory Rapid Appraisal techniques were used to explore the issues listed above.

2.1. Selection of key informants

Caretakers were defined as those who played a key and intimate role in looking after children, especially when they were sick. These included mothers, grandmothers and fathers. In a few cases aunts, uncles and grandfathers were also included in the men or women focus group discussions. Three types of focus group discussion groups were identified:

1. Mothers with children less than six months old these formed key informants to provide information on maternal and newborn care issues.

2. Mothers and fathers with children less than five years old. These formed key informants to provide information regarding health seeking for sick children, home care for sick children and vaccination.
3. Wives and husbands (separate groups) these formed key informants to provide information on FP issues.

2.2. Sample size

A total of 32 focus group discussions were carried out, 17 in Andkhoy cluster and 15 in other districts of Jawzjan (of these 17 FGDs were carried out with Uzbek and 13 with Turkmen and only two with Tajiks). A total of 309 women and men participated. FGDs were carried out in Andkhoy, Khanecharbagh, Qorghon and Qaramqol in Andkhoy cluster and Qoushtepa, Khanaqa, Murdian and Khojadakoh among other districts of Jawzjan.

	Andkhoy # of FGD	Participants	Jawzjan # FGDs	Participants
FGDs with mothers with children less than five years	3	31	3	23
FGDs with fathers with children less than five years	2	22	2	16
Focus group discussion with mothers with children less than six months	3	33	3	30
Focus group discussion with fathers with children less than six months	2	23	2	14
FGDs with husbands	3	28	2	21
FGDs with wives	4	36	3	32
Total	17	173	15	136

2.3. Survey team members and their training

Eight teams of sixteen women and two teams of four men formed survey teams. Five teams including one male team were allocated in Andkhoy cluster and in other districts of Jawzjan province. MOH staff and SC senior health officers supervised each area on alternate days and coordinated the overall FGD exercise.

A five-day training was organized for the survey team members to enhance good interviewing and note-taking skills. The training covered: introduction of interview tools/checklist; interviewing skills with an emphasis on asking the right question and the art of probing; note-taking skills and checking information for correction. Field-tests was carried out for two days followed by further review and refinement of tools and two additional days of training.

2.4. Data collection, tabulation and analysis

Tools with open-ended questions were developed to elicit qualitative information that required training of the survey team members on PRA/qualitative techniques, emphasizing the importance of probing issues as they arose. Three types of interview tools were developed, one for the mothers and fathers with children less than six months, one for mothers and fathers with children less than five years old and one for the husbands and

wives. Each tool/questionnaire was used as a checklist to guide the survey team members and remain focused on the issues. Interviews were carried out in local languages (Uzbeki, Turkmeni and Darri) and data was collected in a notebook. At the end of each day, the data was checked for corrections, issues that required further probing and submitted for translation into English.

All translated versions were then submitted to the CS-19 coordinator and Health Advisor, who reviewed each case and summarized findings. Information from all the summary sheets were further discussed and analyzed, and used to write this report.

3. Difficulties and problems faced:

Because the interview checklists contained only key areas to probe and no specific questions, it was difficult for a few survey team members to ask the right questions and look for the key areas to probe further. It was evident in some case studies that questions like, “what”, “when”, “why” and “how” were seldom asked. Instead of asking questions around the events that occurred during an illness that led to the child’s death, on some occasions a few survey team members were more tempted to ask questions about access to the project’s curative and preventive services. These problems led to the reduction of survey teams from six to four, which is one reason why more time was needed.

The project’s on-going activities did not allow much space to carry out analysis on time and therefore feedback to communities was provided a few months after the survey was completed. While this report gives enough information about decision-making and health care seeking that had negative outcomes, disagreements on methodology to investigate similar issues among survivors and lack of time (due to project’s on-going activities) did not allow the selection of comparative groups as planned and therefore no information is available about decisions made leading to the survival and improved child health.

4. Findings:

4.1 Birth preparedness

4.1.1. Encourage pregnant women to attend antenatal care sessions

In Andkhoy cluster (Andkhoy, Qaramqol, Qorghon and Khanecharbagh), many (Uzbek and Turkmen) men and women mentioned that when a woman is pregnant, they encourage her to attend antenatal care sessions at the basic health centers, because it is important to keep in touch with the health workers who are knowledgeable and refer those with complications to female doctors in Andkhoy town. The female health workers (MCH assistant) also educate mothers and their family members regarding danger signs, maternal nutrition, the importance of rest during pregnancy and TT vaccinations. Most pregnant women go to the clinic alone except for a few who are accompanied by their husbands.

KPC concern¹⁸: To explore in Andkhoy cluster especially in remote villages and in other districts of Jawzjan why women are not seeking ANC and PNC services and why most women are delivering their children at home instead of at a health facility.

Some (Turkmen and Uzbek) women who knew the importance of attending ANC were unable to do so because the clinics were far away and they could not pay for the transportation, and did not have donkeys or horses for travel. Some women (Turkmen and Uzbek) mentioned that they never sought antenatal care because they didn't feel it was important and because they were not sick.

In order to ensure that all pregnant mothers must attend ANC, most participants of FGDs in Andkhoy recommended educating family members in order to raise their awareness and to encourage them to arrange ways to ensure that pregnant women attend ANC sessions regularly. They also suggested that ANC services should be provided in the villages that are too far away from the clinics. Many Uzbek men suggested that the UN must re-start food (oil, biscuits, beans) distribution through the clinic staff again to attract more pregnant women. A few recommended that a clinic in Surkhy bazaar must be constructed (recommended by some Uzbek men).

Many Turkmen and Uzbek women and men in Murdian, Khojadakoh, Khanaqah and Qushtepa districts of Jawzjan, mentioned that if a pregnant woman becomes ill, they seek care from private clinics (in Shiberghan) and local health facilities. However seeking antenatal care (as one element of birth planning) was not mentioned by anyone. Many Turkmen and Uzbek women (Murdian and Khanaqa) contacted mullah to get amulets and prayers and dayas to seek advice for the pregnancy. In a significant number of cases, family members disallowed women to seek care from the local clinics (Murdian, Qushtepa and Khanaqa). Fear of foreign doctors discouraged a few women from seeking antenatal services from the MCH clinic in Shiberghan. One Tajik woman living in Qushtepa said:

“Other women who see a doctor in Shiberghan say that if we go to the hospital to show our pregnancy the kharajee [foreign] people will take us abroad – therefore I don't go”.

4.1.2. Provide special food to pregnant mothers:

Many Uzbek and Turkmen women and men (in both Andkhoy cluster and other districts of Jawzjan) mentioned that they prepare special food containing energy for mothers such as 'Atalah' (flour, sugar, oil). They believed that a special food is important for a mother and baby's health after delivery and for producing milk of adequate quantity. Many (some Uzbek and Turkmen women and men) consider 'Qaraqand', eggs, chicken, dumba (animal fat), meat, oil, rice, sugar, soup, bread, fruits, milk, yogurt and fruits important for pregnant women to

¹⁸ Jawzjan KPC survey September 2003

consume. Some (Uzbek) believed that a pregnant woman must try to eat even if she is vomiting. One Uzbek woman in Khojadakoh said:

“In my thinking a pregnant woman must eat three times a day everything that is available because the baby is growing [fetus growth]. I am poor and I eat nan and yogurt three times a day even I had dil badi [nausea] and vomiting – I also dry melon seeds and eat all the day”

Mother-in-laws decide which foods to buy and husbands provide the financial resources as well as buy those foods which are not easily available in the village. Some (Uzbek and Turkmen) reported that poor economical conditions prohibit many families from buying food of good quality. One Uzbek man in Qaramqol said:

“I think there are many people who can not provide meat to their families. I know two families who eat meat once a month – only when there is khairat. How can a pregnant woman eat good foods if they don’t have money”.

KPC concern 2: Reasons why pregnant women are eating less during their pregnancies?

Some Turkmen and Uzbek women, especially living in Andkhoy cluster and in other districts of Jawzjan, believed that a pregnant woman should eat less to avoid complications during birth – they believed that delivering big babies kills women, especially those who are delivering for the first time. Eating less than usual was also common among some Uzbek and Turkmen primigravidas who felt intimidated by their in-laws and among those who had severe vomiting, lack of appetite and indigestion. Some mothers mentioned *Kum Khooni* (anemia) and believed it was due to eating less, restricted diet and vomiting.

4.1.3. Encourage pregnant mothers to rest

Many (Uzbek and Turkmen men and women) mentioned that at home many family members prohibit pregnant women from doing heavy work, with a few asking pregnant women to reduce their household chores when they are in their third trimester. Some (Turkmen and Uzbek mothers) confirmed that their household chores were reduced and done by other family members. They believed that rest ensures a healthy mother and a newborn. One Turkmen man said:

“I want my wife to be healthy and I also want healthy and safe birth of my baby. Therefore I ask my wife to rest, not to do heavy work and eat good foods”

But there are some (Uzbek) women who mentioned they could not take enough rest during their pregnancy, as they either didn’t have anyone to help them or no one offered any help. They complained of weakness and sleepiness and mentioned that it was all due to too much housework, carpet weaving, fetching water and doing other heavy work. One mother (Uzbek) in Qorghon said:

“I had pains in the lower part of my stomach – my feet – I think this was due to carpet weaving and severe vomiting”.

4.1.4. Prepare to cover newborns

Many Uzbek and Turkmen women, together with their mother-in-laws, prepare clothes, swaddling materials, mattresses, pillows and blankets for the baby. A few (Turkmen mothers) buy a baby's cradle. Some (Uzbek fathers) arrange for wood and fuel to keep the delivery room warm. They believed that 'heat' facilitates easy delivery and keeps the baby warm.

4.1.5. Prepare for the safe and clean delivery

Many (both Turkmen and Uzbek) identify and arrange for the assistance of a trained birth attendant (TBA) at delivery. They believed that the trained birth attendants understand the complications, have clean and 'light' hands¹⁹ and could manage some problems. Some (Turkmen and Uzbek) make sure that a clean birth kit, soap, hot water to bathe the newborn and a plastic sheet are available for the delivering mother. A few (Uzbek) also prepare special foods made up of meat and eggs to give to the delivering mother, to ensure that she has energy for labor and birth.

4.1.6. Saving money

Some Uzbek and Turkmen men and women reported that they save money to buy special food, clothes for the daya (birth attendants) and for doctors and medicines if need be. Generally, in both Andkhoy and other districts of Jawzjan saving money was not actively thought/planned for emergency transportation of women facing obstetric complications. Many (Uzbek and Turkmen) consider delivering at home safe and clean, and mentioned that they only take a delivering mother to a health facility when she faces complications. Only a few Uzbek women and men in Khojadakoh mentioned that they save money for the delivery, especially when the delivery is near – they do this by either selling wheat or sheep (Khojadakhoh). A few (Uzbek) women and men mentioned that looking for transportation and money on loan at the eleventh hour caused the deaths of some women in labor in their neighborhood. An Uzbek man in Qorghan said:

“One year ago my wife delivered a baby at home – after the delivery she had too much blood. I ran to my friends to get some money on loan – my friend helped me rent a saracha (car) and we took [wife] to the local clinic doctor [MCH assistant?]. She [wife] had so much blood coming – like a slaughtered sheep. Before she [MCH assistant?] could see her she [wife] died. It was God's will...my son is still living...it was night and we were not able to do anything”

4.1.7. Look for danger signs during pregnancy

Many mothers (Turkmen) knew what the danger signs are although very few actually developed any during their pregnancy. They mentioned that they would first contact the MCH worker at the clinics or go to Andkhoy to seek care from doctors if such

¹⁹ . When a baby is delivered without complications, such birth attendants are referred to as 'light handed'.

complications arose. Many (Turkmen and Uzbek) women mentioned that they seek care even if they noted minor ailments – many believed that it was better to treat illnesses/discomfort before it becomes severe. For example: some (Uzbek) sought care from doctors for severe vomiting, fever and cold. One woman (Turkmen) in Khanecharbagh mentioned:

“When I was pregnant I went to see the health worker in the clinic many times. I used to feel my mouth getting dry, my shoulders aching and pain in the lower part of my stomach [abdomen] when I was seven months pregnant-I went to see the female doctor in the clinic [MCH worker] and a daya in our village”.

Some Uzbek women mentioned that they seek care from mullahs because they believed that their prayers would protect their pregnancy from evil eyes or complications. A few (Uzbek) men mentioned that mullahs give amulets, holy water and say prayers especially for pregnant mothers who express fear from delivering the baby.

4.2. Childbirth

In Andkhoy cluster and other districts of Jawzjan, many Turkmen and Uzbek mothers delivered at home with the help of relatives, mother-in-laws, neighbors and daya. They believed that most deliveries occur without complications and therefore it is safe to deliver at home. A few believed that delivery at home is clean and comfortable and no money is spent while a few other considered delivery in a facility a shameful thing. Among other barriers to access, skilled birth attendants and some Uzbek and Turkmen women and men mentioned lack of facility, long distance, lack of transportation and lack of money for transportation. Many (other districts of Jawzjan) reported that their family members do not give permission to deliver in the hospital and some (Turkmen) mentioned that delivering in the hospital is useless as there are no drugs.

Usually the sister-in-law or a mother-in-law decides to choose a birth attendant. Many (Turkmen and Uzbek women) believed that the local dayas are trained and know how to deal with complications. One Turkmen mother in Murdian said:

“When I was delivering – women said I was bleeding. They brought a daya who put inside [inside vagina] me some kind of greasy medicine. My bleeding stopped – but when the baby was born it was dead. I don’t know why my baby died. The doctor could help us – but the clinic is so far from us and we don’t have money to rent the car.”

Some women (Turkmen and Uzbek) who developed complications during delivery were treated by the local dayas who mostly referred complicated cases to doctors. A few used traditional healing techniques for example: a delivering mother developed the symptom, ‘ears making noises’ during pregnancy was treated by a local daya who pulled and rubbed her ears.

4.3. Postpartum care

In the Andkhoy cluster, many Uzbek and Turkmen mothers mentioned that a *daya* came to see them and the newborn after the delivery. They checked the newborn for complications, problems with breastfeeding and checked for maternal fever. Usually the mother-in-law and mothers themselves decided to ask the *daya* to come for postpartum care several times after delivery and are paid in kind (cloths and foods). In a few cases (*Khanaqa*) *dayas* were asked to come only because the new mother or the newborn was sick.

Many (Turkmen and Uzbek mothers) reported that no one from the clinic to provide postpartum care, including a few (Uzbek women) who lived near a facility. Many mentioned that the facility staff provides a postpartum check-up when the mother and the newborns are taken to the hospital for the child's vaccination and weighing.

Many Uzbek and Turkmen mothers living in far flung areas (in Andkhoy cluster and other districts of Jawzjan) reported that the clinic staff should provide PNC care in their villages because they are far away, and many people in the village lack transportation and money to get to the clinic.

4.4. Immediate newborn care

KPC concern 2: What are the issues related to the very initial handling of the newborn baby, particularly relating to bathing, skin-to-skin contact with the mother, and early initiation of breastfeeding.

4.4.1. Cord Care

In the Andkhoy cluster Many Uzbek and Turkmen mothers reported that the cord was cut soon after the delivery. They believed that cutting the cord while the newborn is still warm is very important because it prevents the newborn from catching diseases. Many mentioned that their practice of cutting the cord with a carpet knife has ended. They now use new razor blades and they learned this from the clinic health workers.

Unlike in the Andkhoy cluster, many Uzbek and Turkmen women (especially in *Khanaqa*, *Murdian* and *Qushtepa*) mentioned that they wait for the placenta to deliver and then the cord is cut. They believed that cutting cord before the placenta is delivered makes the newborn weak and flaccid. Usually they used a sharp knife to cut the cord – many had not heard of clean birth kits.

4.4.2. Bathing newborns

In both Andkhoy cluster and in other districts of Jawzjan, many Turkmen mothers reported that they bathe the newborn after it is born and then wrap it in a warm cloth. They believed that this keeps the baby clean and warm. After the delivery, many (Turkmen and Uzbek) place the baby with the mother so that she could start giving her breast milk. Some believed that this also helps deliver the placenta. Usually if the cord is cut immediately after the delivery they first bathe the baby, put on the new clothes, swaddle, and then give the baby to

the mother. The whole process takes about thirty minutes. Among those who wait for the placenta to deliver, they cut and tie the cord and bathe the baby. The process takes more than an hour before the newborn is laid beside the mother.

A few mentioned they wait for couple of days before they wash the newborns to prevent the newborn from catching illnesses. This was more common among those women whose previous newborn died of *Haftak* (neonatal tetanus-Andkhoy). Bathing is also delayed if the newborn is blue or is thin (LBW). Some (Uzbek - Khojadakoh) prepare the delivery place by spreading sand and covering it with a clean old sheet, believing that the sand absorbs the amniotic fluid during delivery. Occasionally they would also use sand to dry the baby and then give it a bath.

4.4.3. Health seeking for the newborns

Seeking care outside the home for sick newborns is a common practice. Many Turkmen and Uzbek mothers (in Andkhoy cluster and other districts of Jawzjan) mentioned that their newborn developed complications (abdominal pain, cough, cord bleeding, weak/LBW, white mouth) for which they contacted doctors. A few (Uzbek men) mentioned that their child developed *haftak* (neonatal tetanus) and treatment was sought from doctors but they died later at home. A few (Uzbek mothers) informed that the newborns developed jaundice and were taken to the mullah or were treated by daya.

Some (Turkmen and Uzbek) waited at home for the sick newborn to become well on its own with a few using home remedies such as Asfand (burning herbal seeds). Usually lack of money prevented them from seeking care from a health worker.

4.4.4. Giving Colostrum/initiating breastfeeding

KPC concern: To explore why some mothers are delaying the initiation of breastfeeding?

Some Turkmen and Uzbeks (In Andkhoy and other districts of Jawzjan) women mentioned that they give their breasts to their newborns one or two hours after the delivery - after the baby has been given a bath and has been swaddled. They believed that this gives energy to the baby and helps develop a bond between the mother and the newborn.

Many Uzbek and Turkmen (common in Murdian, Khanaqa and Qushtepa) keep the newborn away from the mother for one or two days because of the fear that the child would contract illnesses from the mother's milk – this is more common among those who encourage the mothers to discard the colostrum. They give glucose water or powdered milk to ensure that the child is not hungry, while mothers empty the breasts of the old milk. This practice was also reported by some Uzbeks and Turkmens living in Andkhoy cluster who believe that the white liquid breast milk comes after three days and that the yellow and thick (colostrum) is bad for the newborns.

4.5. Family Planning

KPC concern: To explore with men and women how FP decisions are being made by couples and the reasons why.

4.5.1. Deciding about the number of children

Usually couples do not decide how many children they will have as this is considered shameful and a sin. Many Turkmen and Uzbek women and men (in both Andkhoy and other districts in Jawzjan) had between six to seven children and reported that both the husband and wife are willing to have as many children as possible, as this is Allah's will. One Turkmen man in Khanecharbagh said:

"If Allah gives us more children we will be happier and pleased because children are Allah's gift for the human beings. I have seven [children] at home and if Allah gives me more I will be happy"

Only a few Uzbek and Turkmen men and women (in both Andkhoy and Jawzjan) mentioned that they want to have a limited number of children and the couples do discuss this among themselves. They believed that poor economic conditions and poor maternal health are reasons to have fewer children.

4.5.2. Reasons for having many children

Most Turkmen and Uzbek women and men mentioned that the more children they have, the happier their family members are, especially the mother-in-laws. They believed that Allah promised to feed them and therefore gives more food if we have more children. Some Turkmen and Uzbek men (in both Andkhoy and other districts of Jawzjan) mentioned that people want to have many children to replace the population lost to the war in Afghanistan. A few Turkmen (in Khanaqa) mentioned that it is important to bring more children to increase the population of Muslims. One Turkmen man in Khanaqa said:

"Stopping children to come to the world is sinful – Allah gets angry – he wants us to bring more children so that the number of Muslim umma [followers of Allah] increases – the number of people saying prayers increase."

A few Turkmen men (in Khojadakoh) mentioned that children, both girls and boys, bring fortune. Girls earn a heavy bride price when married, and they also help mothers with household chores. Many believed (mostly Uzbek and Turkmen men) that people want more children, especially sons, because they assist their fathers in bringing in additional financial resources for the family. Sons are also important so that the assets and lands to remain with the family, as indicated by some farmers living in Khojadakoh. This desire for male children is one of the reasons why some women (Uzbek and Turkmen) preferred, or were forced to bear more children. One Uzbek women in Andkhoy said:

“I have four daughters and one son and do not want to deliver again. But my husband says that I must deliver one more time. Maybe Allah will give a son this time.”

One Turkmen man mentioned that his wife delivered the second child seven years after the first one but they never used a FP method. He believed that *“Its all Allah’s will – he is the one to give [children] or not to give – we have no control”*

4.5.3. Reasons for having smaller family

Some (Uzbek and Turkmen) women mentioned that they are happy with four or five children and do not want to deliver more. They believed that more children consume resources and affects the family’s economical condition. One Uzbek mother of four children in Qorghan said:

“I think having more children is good, but I think having four or five is enough. People in this area are poor and cannot bring up many children. Some women are busy weaving carpets and if they get pregnant they stop and the situation [economical] goes down. The more we deliver the more poor we become.”

Some women (Turkmen and Uzbek) expressed that bearing children ‘shir-ba-shir’ (getting pregnant every year and a half) causes a mother to become weak and tired, yet many women deliver babies every year. Mother-in-laws and husbands were mentioned as decision makers quite frequently especially by women who had a desire to stop bearing more children. One forty-five year old woman said:

“My husband and his mother are happy when I give birth every year. I feel sleepy all the time but I am not able to take rest. I have to prepare food and feed nine children. I feel very weak and am not as fast [fast to work] as I used to be – my children ate my energy.”

A few women (Uzbek and Turkmen) find their own way to use a FP method. One Uzbek man in Andkhoy said:

“Some women buy injection to stop pregnancy, which they get from the doctors and they do what the doctors tell them. Many husbands don’t even know.”

Some Uzbek women and men (in Khojadakoh) recommended that the local clinics must have FP services and were aware of oral contraceptives, condoms and intrauterine devices. One Uzbek woman in Khojadakoh said:

“I get pregnant very soon every time [after every pregnancy]. If we go to the local doctor and get anti-pregnancy tablets and injection it will be good. But they [local clinic] don’t have. I once went to ask them if they can give me a loop [IUD] – they said there is no woman [female staff] and they don’t have [IUD]”

4.5.4. Reasons for not using FP methods

Only a few, especially Uzbek women, were using modern FP methods such as injections and pills. Most (Turkmen and Uzbek) were unaware whether people use any modern FP methods in their community. They believed that Allah gets angry if they used a FP method. One Turkmen man said:

“As much as Allah gives [children] we like because if we take anti pregnancy drugs Allah might be angry at us. We don’t make any plans to stop children coming.”

Many (Turkmen and Uzbek) men and women were unaware of types of FP methods. Some Turkmen women and men believed that using FP methods is not only a sin, but harmful and can cause infertility, swelling and many other women’s disease. Some Uzbek women, who used injections to prevent pregnancy, stopped taking them due to the fear of side effects. One Uzbek woman in Qorghan said:

“I know of a woman who used some kind of anti-pregnancy medicine but afterwards she acted like someone with weak nerves. Everyone said it was due that medicine. Now she does not take. I am afraid to use such medicine.”

This fear of side effects also discouraged many Turkmen and Uzbek women in both Andkhoy and Uzbek, who are willing to adopt FP. One Uzbek women in Khojadakoh said:

“Till now I have not used any anti-pregnancy medicines. If there are any medicines that have no harmful effect I am willing to take. People say that these medicines are harmful – women cannot bear children any more in their life.”

4.5.5. Lactational Amenorrhea Method (LAM)

In both Andkhoy cluster and in other districts of Jawzjan, many (Turkmen and Uzbek) women and men did not know about LAM. While very few (Turkmen and Uzbek mothers) knew that exclusive and frequent breastfeeding could delay pregnancy for the first few months after delivery, many believed that whether they breastfeed or not they get pregnant within few months after their delivery. Most (Turkmen and Uzbek men and women) mentioned that mothers gave birth *shir-ba-shir* (i.e. from one breastfeeding to another-usually within one and a half years after their last delivery). Some men mentioned that their wives breastfed their children for two years without getting pregnant but did not relate this to LAM. However there were many Turkmen women (in Khanaqa) who showed interest in learning about LAM.

Some Turkmen women used to eat wet, uncooked Mash (a type of lentils) while they were lactating, in order to prevent getting pregnant every year.

As soon a woman knows she is pregnant, any of her infants who are still breastfeeding are then switched to other milk (cows milk, powder milk and formula) and soft food (soaked biscuits and porridge/sholla). Some women stop breastfeeding three months before the birth of the next child.

4.5.6. Sources of FP methods are not known

Most Uzbek and Turkmen women and men didn't know about the sources of FP methods and information. This was common both in the Andkhoy cluster and in the other districts of Jawzjan. A few couples wanting to adopt FP could not do so because they did not know where FP services are available and considered it shameful to ask. Only some Uzbek women in Andkhoy, Murdian, Aqcha and Khojadakoh mentioned that a few women get FP supplies from their local clinic staff (MOH's BHC) and dayas.

In Khanaqa, many Turkmen women mentioned that their clinic does not provide any FP services or information and recommended that for those women who want FP services or information, the clinics provide this.

4.5.7. Preferred sources of FP methods and information

Many Turkmen and Uzbek women recommended that the clinic staff should train local dayas (trained birth attendants/female health volunteers) and provide them with FP methods so that those who want to adopt FP or need information could access them. A few Turkmen and Uzbek men and women (in Khanecharbagh and Khojadakoh) recommended that health workers should train mullahs and community based health workers. One Turkmen man in Khanecharbagh said:

"I don't use FP method – many people do not want information or methods. I think people like Mirberdi [former outreach worker] should be trained and clinic staff should give him supplies [FP methods] so that men who want [FP] get it.... if men want."

A few Uzbek men (in Khanaqa) recommended that the best way to provide information regarding FP is through radio and television as those who are shy can get this information and know where to get the FP methods.

4.5.8. Preferred FP methods

While many Turkmen and Uzbek women and men did not practice FP, they were aware of some modern FP methods. Common FP methods used in the area which were mentioned are oral contraceptives and injections (Depo Provera), and a few Turkmen men (in Khanaqa) mentioned that some people who have large families use condoms.

A few Turkmen women in Khanaqa reported practicing abstinence because their husbands were away working in Iran, Mazar and Kabul.

4.6. Health seeking and home care

KPC concern: To better understand health seeking behavior and home care for sick children especially explore why many mothers are decreasing the amount of fluids and food they provide to sick children – why are so few mothers providing ORS to treat childhood diarrhea.

KPC concern: Are they using home remedies to treat ARI before they seek care outside? What are these home care remedies and when do they use them? Why a few mothers are taking their sick children to BHCs.

Many Uzbek and Turkmen men and women (in Andkhoy clusters and other districts in Jawzjan) mentioned that the common illnesses among children under five years of age are pneumonia, sore throat, diarrhea, typhoid, cold/cough, earaches, neonatal jaundice and constipation. Malaria and neonatal tetanus was reported more in Murdian, Queshtepa and Kahanqa districts of Jawzjan. The following table captures local terms used for these diseases, their causes, signs and symptoms or danger signs:

Diseases	Local terms	Causes	Signs and Symptoms	Danger signs
Pneumonia	Sanchiq/ khila Suagh outan (Turkmen) Sanlchigah Saugh oran	Child gets cold Walks bare foot Child is bathed	Cries Cannot breathe Fever Vomiting Fast breathing	Shaitanlain (convulsions) Pallor/blue High fever Fear Chest makes ghiz ghiz sounds
Throat ache	Baghiz oghreq/Tipki Turkmen Tamagh-aghrigh Alqum-shishma Kekertak aghrigh	Cold weather Eating sour things. If child is sad	Hoarse voice Cannot suck breasts Cries Body stiff (shakh).	Cannot suck breasts Ghadud (lymph nodes) Weak/tired Cannot eat/ache Cannot breath
Diarrhea	Qarinaghrigh/ ichgitma. Turkmen Ichkitma Qarnaghrig	Child walks bare foot Drinks cold water Hot weather. Malaria Babies who fall Bad water Stale food	Child becomes thin Sunken eyes Tired/weak Too thirsty Vomiting Pus/blood Watery stool Fever	Weak/tired (lethargy) Cannot drink/eat Unconsciousness Pus/blood
Muriqa	Qizghin kasal	Hot weather Dirty things Fear.	Restless Fear Dry lips Delirium	
Cold	Saugh orma/zik Turkmen Oskoluk/oskulma	Walks in cold weather Walks bare foot.	Restless Headache Coughs Fever.	
Earache	Qulagh aghrigh	Cold weather.	Cries Nods head	Small red spot around ears Cries too much Restless
Neo-natal jaundice	Sarighlama Turkmen	Mothers eating eggs, fat, oranges	Eyes yellow Urine yellow Body yellow	Yellow eyes Nail embed in the skin Cannot breastfeed

Diseases	Local terms	Causes	Signs and Symptoms	Danger signs
	Ughlan Mehnati Urma Kasal			Blueness/cyanosis Convulsions
Constipation	Ich qaitama Ich qaitan	Fever Mother eating potatoes and eggs If opium is fed	Child weak	
Leishmania	Pashakhordagy	Mosquito	Skin sores Watery discharge	Face looks ugly
Whooping cough (Murdian)	Kuk yutal	Cold weather	Child becomes weak Cough and vomit	Small children die
Neonatal tetanus	Haftak	Caused by jinnis and unclean things	Child cries/ no BF Has convulsions	The child always dies

4.6.1. Home care for the sick child

For example:

- For pneumonia they apply home remedies first. This includes massaging the chest with oil and vicks and covering the chest with cotton. If the child does not get better they take him/her to a doctor. This was common among both Turkmen and Uzbek.
- For throat ache they rub the throat with oil or vicks or put 'zmch' (herb) in the fire. If the child does not get better they take it to Mullah or a daya who presses the tonsils hard or refers the child to a doctor. Older, experienced women are also consulted when a child has a sore throat or cough and they massage the child's chest and make small cuts on the shoulder with a blade to allow bad blood to pour out. Some (Turkmen) boil turnips and give soup to children with sore throat.
- For diarrhea, many give a pill 'half the strength of an adult's dose'. Most give green tea and soup of onion. Some give opium in yogurt, and in winter they wrap the chest with cotton. If the child does not get better they take it a mullah or a doctor. Many also mentioned giving ORS. Many also mentioned giving increased amounts of breast milk and other fluids. They believed that breast milk gives energy to a sick child and prevents hunger and weight loss. Some (Uzbek) mentioned giving water of *aash* and rice. Some (Turkmen and Uzbek) give root of *undoz* (herb), opium, pea soup or powdered skin of pomegranate to stop diarrhea. Many (Turkmen) consider prolonged diarrhea an effect of evil eyes and a condition to be treated by mullahs.
- For earache, many (Turkmen and Uzbek) drop breast milk in the affected ear or oil, tea or perfume. If the child does not get better, then they go to a doctor. A few Turkmen fetch pious salt from mullah and mix it with water and drop it in the ears.
- In neonatal jaundice the mother does not eat eggs, meat and oil (Turkmen) and they to a mullah for dam/prayers.
- Some Uzbek women take a child with whooping cough to a shrine. They wait and the child becomes well.
- For convulsions (Turkmen) they use the skin of the hen on put it on the child's stomach. The child sweats and becomes well.

Most (Turkmen and Uzbek) women and men in Andkhoy cluster believed that a sick child should be given plenty of water and fruit juices to drink. They believed that fluids keep the body fluids in balance and some fruits juices (water melon juices) helps reduce fever. Some (Turkmen and Uzbek) mentioned that feeding nutritious food like shola, hot milk and breastfeeding are important.

Giving less fluids or stopping altogether were practices noted in some areas in other districts of Jawzjan especially Murdian and Qushtepa. Also use of ORS for children with diarrhea was uncommon. Many participants (Khojadakoh, Qoushtepa and Murdian) mentioned that ORS was not available in the community nor was it provided by the clinic for people to keep at home.

4.6.2. Seeking care outside home

In both Andkhoy cluster and other districts of Jawzjan, when a child is sick many (Uzbek and Turkmen) first contact a doctor and either get medicine from the clinic or buy them at a local pharmacy. Many mentioned the importance of giving oral medicines and injections if a child is sick. Many found paying Afs 5-10 in the clinic cheaper than paying private practitioners Afs. 300. However, many Uzbek and Turkmen mothers (living in the remote areas) mentioned that long distances to doctors, lack of transportation and money are main reasons why some families first provide home remedies to sick children and only seek care from a doctor when sick children do not get better. A few Turkmen (Murdian) found the language of the health workers working in the local area difficult to understand and hence choose home remedies first or seek care from mama daya.

Many caretakers (Turkmen and Uzbek) consider illnesses the effect of evil eyes, especially those that are identified by the presence of convulsions, delirium or discoloration (yellow) or last a prolonged period/are chronic. They travel long distances to seek a cure from religious leaders/mullahs on donkey carts or by walking with some spending as much as Afs 200-300. One Uzbek father in Qaramqol said:

“Some time ago my child had pneumonia and I took him to the doctor – he gave him [son] some medicines but my child remained sick. As many days passed by I decided to take him to a Mullah – who said to me if I ever took my son to a doctor – I yes said I did but the doctors couldn’t treat my son – the Mullah nodded his head – thought for a while and gave me a little Isfand [herbal seeds] and said to mix the it with some dough and put it on the chest of the boy. I returned home and I did all what mullah told me to do. After a day my son got cured and could thank Mullah enough. Now my son is six years old but he looks like a 15 years old boy”.

4.7. Child immunization

To explore why so few mothers have EPI cards for their children. Are there any cultural, economic, or systemic factors that might be leading to the low EPI coverage and discuss ways that the project can increase this coverage.
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Most Uzbek and Turkmen men and women (Andkhoy cluster) mentioned that their children are vaccinated and for many years measles outbreaks have diminished. One man in Qorghon said:

“Before every year many children used to get surkhaqan (Measles) and many children used to die. But now all people want to get vaccine for the children. Since four or five years only few children develop this disease [measles]”

Only some Turkmen and Uzbek men and women (in other districts of Jawzjan) mentioned that their children have received vaccines in the form of injection. Many Turkmen and Uzbek women mentioned that the reason why some children are not vaccinated is fear from side effects (pain at the site, fever, etc). Some (Uzbek mothers) mentioned that vaccines makes a child restless due to which mothers cannot weave carpets or do house-chores therefore they avoid taking a child back for vaccination. Many did not understand the importance of keeping the card. They said that the doctors in the local clinic never told them to do so.

Many Turkmen and Uzbek women and men recommended that community education addressing these reasons is one way to increase vaccination coverage among children. A few (Uzbek) also mentioned that food distribution could attract many mothers to bring their children for vaccinations. Some Uzbek women living in remote villages (Andkhoy cluster and other districts of Jawzjan) recommended that the vaccinators must come more often to vaccinate children. One mother in Khanecharbagh said:

“The main problem we face is to walk to the shifa khana - our village is so far away. Sometimes the doctors inform that the vaccine will come – so we wait in one location. The doctors come and weigh our children and give vaccines. We are so grateful to them – they should come more.”

TT vaccine:

Some Turkmen women in Murdian mentioned that women doctors must provide vaccines to women. In Khanaqa and Surkhy bazaar clinics must be opened.

5. Discussion and conclusions

5.1. Antenatal care, childbirth and postnatal care

In Andkhoy cluster, the antenatal and postnatal care coverage is very high with 70%²⁰ of mothers attending three or more visits and 84% receiving at least one postnatal care visit, compared to only 44%²¹ ANC and 29% PNC in other districts of Jawzjan province. People living in Andkhoy cluster are more aware about the importance of antenatal care and seem

²⁰ KPC survey January 2003

²¹ KPC survey September 2003

willing to ensure that pregnant women regularly attend antenatal care as part of their birth preparedness plan. This is due to the fact that basic safe motherhood services have been offered in this area since 1995. Since 2003, the project staff has started integrating birth planning strategies including counseling of pregnant women during ANC clinics, education of the pregnant woman's family members, and training male and female community health committees.

The community's lack of awareness regarding the importance of ANC and PNC, and the low coverage of these services, is due to the lack of MCH services in most rural parts of Jawzjan province (excluding Andkhoy cluster), where most facilities lack trained female staff and basic safe motherhood services, and do not extend any community education and awareness programs.

However, in both Andkhoy cluster and other districts of Jawzjan, most women deliver at home and are assisted by the TBAs/dayas. While in Andkhoy these TBAs are trained and assist about 60%²² of delivering mothers, in the other districts of Jawzjan they are untrained and attend most home deliveries. While home delivery has been practiced for many years, lack of skilled birth attendants, lack of delivery facilities in the local clinics, lack of money and transportation are reasons why so few mothers have access to skilled birth attendants or deliver at facilities.

This focus group discussion exercise found many families making an effort to provide nutritious foods and rest to pregnant women with mother-in-laws and husbands playing a positive and supportive role. This is an opportunity for the project staff to build on and promote good eating habits and rest among pregnant women, while also taking into account factors like poverty, poor appetite, nausea, vomiting and fear of complications at the time of delivery/big babies. These factors prevent many pregnant women from adopting good eating habits during pregnancy. It is also important to involve mother-in-laws and husbands when offering nutritional counseling to pregnant women both at the facility as well as during home visits. Maternal nutrition must be integrated as one of the birth planning elements.

There is too much dependence upon traditional birth attendants both trained (Andkhoy cluster) and untrained (other districts of Jawzjan). TBAs provide some antenatal care, assist in deliveries and many visit their clients during postpartum care. Mother-in-laws and other family members make these arrangements. While this tradition of using TBAs/dayas is not new, TBA training, lack of skilled birth attendants and lack of delivery facilities in the local clinics has further strengthened this dependence. Many studies²³ have shown that while TBA training resulted in a significant decrease in infections (intrapartum fever) and retained placenta, there was a significant increase in the rate of women with prolonged labor (more

²² KPC survey January 2003

²³ Sibley and Sipe, 2002; TBA Training and Effectiveness, A Meta-analysis.

4.1. Smith, JA, et al, The impact of traditional birth attendant training on delivery complications in Ghana, Health Policy and Planning;

4.2. Goodburn, EA, et al, Training traditional birth attendants in clean delivery does not prevent postpartum infection, Health Policy and Planning

than 18 hours) because TBAs did not possess the necessary skills to manage the obstetrical complications that can result in maternal mortality. Bringing skilled workers and the management of basic obstetric complications closer to the community, and building closer links between the skilled workers and the TBAs and families, are crucial strategies to reducing maternal mortality. Recruiting and training community based midwives is one of CS-19's goals and this FGD exercise reinforces its importance.

5.2. Newborn care

Because the primary health program in Andkhoy cluster introduced the clean birth kits, their use in the area is very common and ensures that sound efforts are in place to reduce neonatal tetanus (there is also very high coverage of TT vaccine among pregnant mothers). In contrast this practice is very poor in other districts of Jawzjan where basic MCH services are lacking and where many community members named haftak as one of the common illnesses among newborns. Cord care remains one of the important elements of newborn care that must continue in Andkhoy and expand in other districts of Jawzjan.

Bathing a newborn soon after delivery is very common because the local belief considers both the amniotic fluid and vernix dirty and therefore need to be washed away or removed with the help of sand. Waiting for the placenta to deliver, cutting and tying the cord, bathing the newborn, all consume a lot of time during which a newborn is exposed to developing hypothermia. Wiping a baby with a piece of clean cloth/towel and handing over the newborn to the mother to initiate breastfeeding immediately are important ways to prevent hypothermia and initiate early breastfeeding. These elements of newborn care need to be integrated within MNC strategies in both Andkhoy cluster and in other districts of Jawzjan. It might be important to review the Pakistan Newborn Care materials to see if these could be adapted for the local use.

Also please see the breastfeeding report September 2003, which gives details of breastfeeding and weaning issues.

5.3. Family Planning

Family planning is favored among very few community members in both Andkhoy cluster and in other districts of Jawzjan province. The religious belief that FP is sinful discourages many to adopt FP methods, including some who want to have fewer children. This indicates a need to work with religious leaders and mullahs to incorporate Islamic teachings about FP.

Generally, couples do discuss the number of children they want, leaving this to Allah. Many women emphasized strongly that they do not want to bear more children, but were unable to make this decision because of other decision makers such as mother-in-laws and husbands. Many community members believe that FP is about 'not having children' as opposed to 'planning the number of children' and adopting FP based on 'informed choice'. This demonstrates that it is important to educate family members about the importance of FP and promote the concept of informed choice, both among the health workers and the community members.

Some who do want to use FP methods are not doing so because of misinformation and fear of side effects. LAM is commonly practiced, but many community members do not understand that LAM is one way to prevent pregnancy, especially in the first few months after delivery. This shows that the FP strategy must incorporate effective client counseling in order to address the fears about side effects, and to help clients choose another method (if the first one is not working). Another opportunity is to educate mothers and her family members, especially during the postpartum period, about the concept of LAM and how to use it. However, the postpartum period is the best time to discuss all FP options.

Recommendations:

Recommendation 1: Lessons learned from Andkhoy could really help develop similar MNC/safe motherhood services in other parts of Jawzjan province, especially now with the government's BPHS strategy to increase female staffing. MNC training to the health staff, improving supplies and equipment in the health facilities, extending community education and awareness activities through CS-19 MCH promoters and recruiting and training CHWs especially in the remote areas are important strategies to ensure that most pregnant mothers receive ANC services (Please see Andkhoy KPC survey recommendation numbers 6.3 to 6.3.5)

Recommendation 2: While developing MNC strategies in the other districts of Jawzjan and parts of Andkhoy cluster, socio-economic barriers identified in this FGD exercise must be taken into account. One way to do this is through integrating these issues in the birth planning strategy. For example lack of money and transportation at the time of emergency was cited as one of the major barriers – integrating messages on the importance of saving money right from the first trimester, identifying locally available transportation, identifying trained birth attendants and/or skilled birth attendants and the address of the referral facility beforehand and mobilizing support from the community elders in order to develop community based alarm and transportation system will help access help from skilled health providers on time (See Andkhoy KPC survey recommendations 6.3, 6.4 and 6.5).

Recommendation 3:

Identify and establish linkages with the recommended midwife training institute (Provincial Hospital Mazar). Assist MOH with the recruitment of potential community-based midwives. Support community-based midwives' training through providing scholarships.

Recommendation 4:

Review and refine existing (or develop) health education messages and materials on maternal nutritional and rest. Take into account the successful nutrition habits as identified in this FGD exercise to promote good eating habits among pregnant women and their families. Integrate maternal nutrition as one of the birth planning elements (also see Andkhoy KPC survey 2003 recommendation 6.3.3.).

Recommendation 5:

Review Pakistan newborn care materials and integrate newborn care in the existing safe motherhood training modules. Especially include modules to promote immediate newborn care (resuscitation, cord care, drying/warming, early initiation of breastfeeding) and newborn care during the postpartum period, within the first six weeks. Also include recognition of danger signs in the newborn and health seeking behavior guidelines.

Recommendation 6:

- Develop ways to work with religious leaders and mullahs and to incorporate Islamic teachings about FP.
- Educate family members about the importance of FP Promote the concept of informed choice among both the health workers and the community members. Provide training on FP and counseling skills to the CS-19 MNC officer, MOH staff and the health facility staff.
- Promote client counseling in order to address fears of side effects, help clients choose another method (if the first one is not working).
- Educate mothers and their family members, especially during the postpartum period, on the concept of LAM and how to use it.
- Use the postpartum period (the best time) to discuss all FP options.

Annex 1.

Focus Group Discussions (mothers or fathers with children under 5 years)

1. What are the most common diseases in your area that affects the children under the age of five years? ((Use the table below to ask the following questions)

Name of the diseases	Local terms used for these diseases	How are these diseases caused	What happens when a child gets these diseases?

2. What do you when a child contacts these diseases? (pick the most important disease like ARI, diarrhea, fever, measles, etc)

Name of the diseases	What the most common things you do the first time?	Then what do you do?	And why do you do these?

3. What are the danger signs among children who have these diseases? What are their local terms? Why do these signs indicate danger?

Name of the diseases	What are the signs indicating danger? (write down local terms and their meaning)	What happens when a child with this disease has this sign
Watery diarrhea		
Child with cough		
Fever		
Other		

4. What are some of the home remedies do you do for your children when they have these diseases? What are these things? How do you do these? Why do you do these? (Pick most common disease and not all of them)

Name of the diseases	What home remedies do you do?	How do you do these things?	And why do you do these? What are the benefits
Cough/ARI			
Diarrhea			
Dysentery			
Other			

5. When a child is sick, how much fluids should be provided? Why?

What about breastfeeding? Why?

What about giving foods/feeding? Why?

If a child has diarrhea? What about ORS?

6. You said that you seek cure from outside home? From whom do you seek? Why do you seek? What are the type of cure these providers give?

Type of the providers	Why seek cure from this provider?	Type of cure this provider gives?	How much do you pay them?	How do you travel to them?

7. Sometimes it may be difficult to access these providers. What are some barriers? And how do you overcome these barriers? (the barriers could be lack of transport, money, female staff, language, etc)

Name of the providers	Main barriers faced? (lack of transport, money, language, gender, no permission, center closed, staff not present, etc)	How do you overcome these barriers or then what do you do?

8. Have you ever had your children (less than 5 years) vaccinated?

Where did you get your child vaccinated?

Why did you have your child vaccinated?

When should one not vaccinate a child?

We found (KPC survey) that very few mothers had their child's EPI cards. Why is this so? Why do they have so few cards?

We also found that very few children had received all the course of vaccines. Why is the coverage so low? What are the reasons?

Are there any local beliefs about child vaccines or TT vaccine? What are these beliefs?

Different beliefs regarding TT	Why seek cure from this provider?

How can the coverage of vaccine be increased among children? Give us some solutions?

How can the coverage be increased among women for TT vaccine?

**Focus group discussion with mothers with children less than six months, who delivered at home.
(not more than 5-8 mothers)**

Date: _____

Ethnic groups: _____

Number of participants: _____

1. When you were pregnant, what preparation was carried out by you, your husband and other family members before the birth of this child?

Birth preparedness	By whom	Why

2. What are the most important things a family must include when preparing for the arrival of the baby (birth preparedness)?

3. If a pregnant or a delivering woman faces complications, what do you do?

4. How do you make sure that money is available for emergency transportation in case there is a need?

5. When you were pregnant with this child how many of you went for a check-up? Where? Why?

Those who went to seek Antenatal care		
Types of health providers	Where?	Why did you go to these health providers

For those who did not, why didn't they go to seek antenatal care services? What were the barriers?

Mothers	Reasons for not seeking antenatal care, or barriers

6. When you were pregnant with this child, did you face any complications? What were they? And what did you do?

Types of Complications	What actions were taken?	Why were these actions taken?	What were the barriers in taking these actions?

7. How much should a mother eat during pregnancy? What must she eat? Why?

Foods to eat during pregnancy.	Why should she eat this?	How much should she eat this much?

It was found (in the KPC survey) that many women ate less during pregnancy? Do you know why? What are the reasons of eating less (probe for traditional beliefs and other reasons?)

8. Where did you deliver this child? And who assisted you during delivery? Why do you use this birth attendant? Who decided to use this birth attendant?

Where did you deliver this baby	Who assisted you during the delivery?	Why did you use this birth attendant?	Who decided that you use this birth attendant?

Were there any reasons for not delivering the baby in a hospital or a clinic?

Mothers	Reasons for not delivering the baby at a hospital or a clinic?

9. Did you face any complications during the birth of this baby? What? What did you do?

Complications during birth	What actions were taken?	Who decided to take these actions	What were the barriers in taking these actions?

10. After this baby was born, did someone come to examine you and your newborn?

Type of health provider?	Did the health provider check you and your baby?	Why did you use this health provider?	Who decided that you use this health provider?

What were the reasons that some of you were not examined?

We found (in the survey), that health workers examined a few women and newborns after delivery? Why is this so? What are the reasons? (probe by asking what else, then what – collect as many reasons as possible)

What suggestions do you give to ensure access to antenatal care?

What suggestions do you give to ensure access to postnatal care?

11. As soon as the baby was born, when was the cord cut? With what? Why?

When was the cord cut?	Why was the cord cut at this time?	With what was the cord cut?	Why was the cord cut with this?

12. After the baby was born, what did you do with him/her? And why? (below are the two examples, but probe for the rest,

Things done with a baby as soon as he/she was born	Why did you do this?
Baby delivered but waited for the placenta to come out.	
Cut the cord as soon as the baby was born Other:	
Bathed the baby soon after he/she was born. Other:	
Wrapped the baby in warm clothes and put him/her in the cot Other:	
Dried the baby with a piece of cloth (delayed bathing) Other:	
Cut the cord and gave the baby to the mother to breastfeed Other:	
Other:	

Probe: where did you first placed/laid the baby when it was born? And why?

How long after the baby was born did you give it to the mother?, why?

13. In the first 28 days after birth of this baby, did this baby contract any illness? Or face any complications? What? What did you do? Who decided? What were some barriers?

Complications/illness birth	What actions were taken?	Who decided to take these actions	What were the barriers in taking these actions?

Breastfeeding

14. When do mothers first put babies to their breasts after they are born?

Some mothers give their breast milk 2-3 days after delivery, why do you think they do this?

15. When is the best time to introduce weaning foods to children? What are those foods? Who decides?

Types of foods	Time to introduce other food	Why this time it is introduced?	Who decides

Why do some women introduce weaning foods before children are six months old?

Who do some delay introducing foods?

Focus group discussions with Husbands and Wives (of reproductive age)

1. When a mother is pregnant what preparations are carried out by her, her husband or other family members before the birth of a baby?

Birth preparedness	By whom	Why

2. How do families usually decide about number of children they want?

Who influences this decision the most and why?

How do wives and husbands make this decision?

Why not? Who else makes this decision?

4. What do you think about FP? In particular about modern FP methods (take names of the FP methods)

5. In your knowledge, which FP methods are most commonly used in this community?

Why are these methods common (take names of each FP method mentioned)

Where do they get these supplies?

6. If a couple wants to use one of the FP methods, from where would they usually get this information? Or advice?

7. In your opinion, from where would a couple (or one of them) feel comfortable getting information regarding FP and FP methods?

8. Breastfeeding delays pregnancy in many women – do you know what is required to use this method (LAM) to prevent pregnancy.

For how long LAM could work effectively?

ANNEX III

REACH Reports

REACH Grantees Progress Report

Organization: **Save the Children Federation, Inc. (SC/US)**
03-00021-00

Contract number: **EEE-C-00-**

Project title: **Rural Expansion of Afghanistan's Community-Based Health Care Program in Andkhoy, Qaramqol, Khancharbagh, and Qurghan Districts in Faryab Province and Qarqin, Khamyab, and Khwaja du Koh Districts in Jawzjan Province**

Project start date: **15 / MAR / 04**

End date: **31 / MAR / 06**

Period covered by this report: **15 MAR 04 – 15 JUN 04**

Report submission date: **15 / JUL / 04**

Contact person: **Leslie F. Wilson, Deputy Director**
070.298.230 / lwilson@savechildren.org
Communication, Advocacy and Program Support

Telephone and email address:

Mailing address: **Save the Children Federation, Inc. (SC/USA), P.O. Box 642, Kabul**

1. Executive summary of the achievements this quarter

During the first quarter of the REACH project in Jawzjan (including the Andkhoy cluster of districts), key activities were (1) recruitment for REACH staff, which has proved to be very difficult, and (2) intensive liaison and planning work with the Provincial Health Director, Dr. M. Haroon. Toward the end of the quarter, SC/USA was preparing to make decisions on key staff hires, to send a team of two to Bangkok for CDQ/PDQ training in support of REACH activities, and to sign an MOU with Dr. Haroon re: the secondment of Ministry of Health (MOH) staff to SC/USA for the duration of the REACH project.

SC/USA health, finance and program management staff participated in workshops and meetings as requested. Health staff attended the Baseline Household Survey Training in April. The baseline survey was conducted May 2 through May 7, and a follow-up Baseline Workshop was attended on May 10. SC/USA also attended the HMIS training and, as noted, other meetings, e.g., financial management workshops and update/information-sharing meetings for all REACH grantees. Information on pharmacy staffing at clinics and EPI information was also collected and submitted.

Finally, though not under the auspices of the REACH project, SC/USA did continue to support the MOH in basic health activities in the Andkhoy cluster of districts (4 of the 7 covered in the project).

2. Progress Data

REACH Grantees (Save the Children-USA) Quantitative Progress							
No.	OUTPUT INDICATORS	Target LOP	Achievements				Comments
			End of last quarter (#)	Q1	Cumulative Total	Cumulative %	
	SERVICE DELIVERY SYSTEM						
1	# of facilities (First Referral Hospital, CHC, BHC) providing services through use of REACH funds	8		See comments			Start-up of the activity planned for the first three quarters of the project. Clinic handover did not occur during this quarter, though SC/USA did continue support for the MCH clinic and other Andkhoy cluster clinics via another (ending) health projects that supports MOH staff/activities. Progress to be reported next quarter.
2	# of active Health Posts providing services through use of REACH funds	80		See comments			Activity planned for Q2, Q3 and Q4.
3	# (%) of active facilities (First Referral Hospital, CHC, BHC) properly staffed	100%		See comments			Activity planned for the first three quarters of the project, but not begun during Q1 due to overall project start-up delays. However, as also noted, SC/USA did continue support for Andkhoy cluster clinics and health outreach activities/workers.
4	# of villages identified served by community health workers	44		See comments			CHW selection by Community Health Councils planned for Q1/Q2; progress to be reported in Q2.
5	Population in REACH project districts	170,583					<i>Need clarification on how to report on this indicator.</i>
6	Population with immediate access to Basic Health Services	170,583		See comments			Since the project is not yet operational at the HP level, nor fully operational at the facilities level, no data to report.
7	# (%) of health facilities reporting use of health promotion messages related to child health, birth preparedness, FP, nutrition, safe injections	100% (8)		See comments			IEC (health promotion messaging) training for CHWs planned for Q2; use of messages to be reported in Q3 and beyond.

REACH Grantees (Save the Children-USA) Quantitative Progress							
No.	OUTPUT INDICATORS	Target LOP	Achievements				Comments
			End of last quarter (#)	Q1	Cumulative Total	Cumulative %	
	QUALITY OF SERVICES						
8	# (male/female) CHWs started CHW training (first phase) this reporting period	60 (30/30)		See comments			Activity planned for Q2/Q3.
9	# (male/female) CHWs successfully completed training (third phase) this reporting period	60 (30/30)		See comments			Activity planned for Q5, Q7 and Q9.
10	Total number of active CHWs (Male/female)	160 (30/130)		See comments			There are still many female CHWs active in the Andkhoy cluster per previous SC/USA projects there, and REACH-funded CHW activities will be reported in the future.
11	% of CHWs dropped out during this period.	5%		n / a			
12	% of active health posts/CHWs with no stock outs of tracer drugs during the last reporting period	128 (80% of 160)		See comments			HP start-up planned for Q2/Q3; this indicator will be reported on after the Posts are up and running.
13	# (male/female) CHWs received refresher training	100 (0/100)		See comments			Activity planned for Q3, Q5 and Q7
14	# (%) of active CHWs supervised during reporting period	160		See comments			Activity planned for Q2 and beyond.
15	# of Health Workers (BHC, CHC, first referral hospital) received refresher courses during reporting period	44 (24/20) [4.2.2.]		See comments			Training activities for facilities staff planned for Q2-Q4 and Q6-Q8.
16	# (%) of active facilities implementing referral systems for obstetric care	8 (100%)		See comments			Activity (training re: referrals) planned for start-up in Q3 and for subsequent quarterly reporting.
17	# of active facilities using appropriate waste disposal	8 (100%)		See comments			Will monitor and report after relevant training(s); see 15, above, for timing.

REACH Grantees (Save the Children-USA) Quantitative Progress							
No.	OUTPUT INDICATORS	Target LOP	Achievements				Comments
			End of last quarter (#)	Q1	Cumulative Total	Cumulative %	
	IMPLEMENTATION & MANAGEMENT PLAN						
18	Roster of administrative, clinical and training personnel hired	Updates submitted quarterly		See comments			Per work plan hiring is planned for Q2.
19	Inventory report of existing and purchased equipment submitted in semi-annual and end of project reports to REACH, PHO and GCMU	Visits confirm report accuracy		See comments			Due with Q4 report; will submit initial inventory with Q2 report.
20	# (%) of facilities sending in HMIS forms	8 (100%)		See comments			HMIS activities not yet underway; preliminary status report in Q2.
21	Training work plan evaluated and updated	Every 6 months		See comments			Will provide in Q2 to reflect hired staff needs.
	MONITORING AND EVALUATION						
22	# (%) of active facilities receiving OPD patients referred into facility during this reporting period	8 (100%)		See comments			Activity (training re: referrals) planned for start-up in Q3 and for subsequent quarterly reporting.
23	# (%) of monthly HMIS reports of Basic and Comprehensive Health Centers include information on re-attendance for family planning (FP) services and number of new patients per method	8 (100%)		See comments			Will report progress in Q2 or Q3
24	# (%) of Health Posts/CHWs referring children under 5 during this period	60 / 120		See comments			Activity (training re: referrals) planned for start-up in Q3 and for subsequent quarterly reporting.
25	Baseline household survey performed	Q2 (done in Q1)					Conducted May 2 to May 7, 2004

REACH Grantees (Save the Children-USA) Quantitative Progress							
No.	OUTPUT INDICATORS	Target LOP	Achievements				Comments
			End of last quarter (#)	Q1	Cumulative Total	Cumulative %	
26	EOP household survey performed	EOP					
	SUSTAINABILITY AND COORDINATION						
27	# Memoranda of Understanding signed with local district or Community Health Council(s), including listing of community contributions.	35 / 35 (f/m Councils)		See comments			SC/USA has ongoing relationships with Councils in the Andkhoy cluster of districts and will execute MoUs with these groups as well as the newly formed Councils in Jawzjan during Q2, as planned.
28	Average # of Community Health Council meetings attended per active Health Post, this reporting period	3 (1/month/ CHW duo)		See comments			Council trainings/meetings planned for Q2 in Jawzjan, as well as Q1/Q2 in Andkhoy cluster; will report in Q2.
29	Estimated financial community contribution to the project	% and amount agreed		See comments			Will report progress in Q2/Q3, depending on outcomes of trainings/meetings.
30	Amount of funds from cost recovery strategy	% and amount estimated		See comments			To be reported in Y2 of the project after protocols are established and working.

3. **List of attachments to this report:** Signed MOU re: Ministry of Health staff secondment from Jawzjan Provincial Health Director, Dr. M. Haroon.

USAID REACH MONTHLY MINI DELIVERABLES REPORT: Grantee Activities

(Please complete and attach with each monthly invoices)

Organization name: **Save the Children Federation, Inc. (SC/USA)**

Grant number: **BP – 02 – 07**

Province: **Jawzjan, including the Andkhoy cluster of districts (Faryab)**

Districts: **Andkhoy, Qaramqol, Khancharbagh, and Qurghan (Faryab); Qarqin, Khamyab, and Khwaja du Koh (Jawzjan)**

Invoice number:

Invoice amount:

Program title: **REACH (Basic Package of Health Services Delivery)**

Program start date: **15 / MAR / 04**

Program end date: **31 / MAR / 06**

Interim period covered: **1 / SEP / 04 – 30 / SEP / 04**

Report submission date: **18 / OCT / 04**

Contact person: **Leslie Wilson, Deputy Director, Communication, Advocacy and Program Support**

☎ # / e-address: **070.298.230 / lwilson@savechildren.org**

Mailing address: **P.O. Box 642, Kabul**

#	OUTPUT INDICATORS	Achievements			
		End of previous month	This month	Cumulative Total	COMMENTS
SERVICE DELIVERY SYSTEM					
1	# of facilities (First Referral Hospital, CHC, BHC) providing services through use of REACH funds	7	7	7	
2	# of active Health Posts providing services through use of REACH funds	0	0	0	All 80 HPs are ID'ed. CHWs require training and medical supplies; more information below.
QUALITY OF SERVICES					
3	# (male/female) CHWs started CHW training (first phase) this reporting period				All 160 CHWs have been selected: 31 male/129 female. Due to Presidential election-related security concerns, training will begin November.
4	Total number of active CHWs (male/female)	0	0	0	No one selected for CHWs training is an active CHW; 90% are TBAs no longer recognized by the MOH, so all will need basic CHW training.
IMPLEMENTATION AND MANAGEMENT PLAN					
5	# of new administrative, clinical and training personnel hired this month	62	63	63	Hired one additional staff member; the challenge of finding women to fill remaining vacancies continues.

ANNEX IV

CSHGP Data Form

Child Survival Grants Program Project Summary
 First Annual Report Update
 Field Contact Information:

First Name: Dr. Aftab Tariq
Last Name: Ihsan
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City: Islamabad
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Project Information:

Project Description:	<p>This five-year Child Survival Program, Provincial Strengthening in Northern Afghanistan: Capacity Building and Innovation to Support Afghanistan's Basic Package of Health Services in Jawzjan Province, builds upon Save the Children's (SC) work in Afghanistan since 1989, where SC has supported the MOH in the Andkhoy cluster of four districts to increase access to, quality and use of essential MCH services at basic health facilities and community health posts. Significant health policy change in the last year has brought about the adoption of the Basic Package of Health Services (BPHS) for Afghanistan, which will offer a comprehensive list of MCH services all levels of care. In accordance with this new national policy, CS-19 plans to support the BPHS, which will be implemented through The Rural Expansion of Afghanistan's Community Based Healthcare (REACH), a 3-year program supported by USAID, and implemented through Management Sciences for Health. In Jawzjan Province, CS-19 will support these activities by developing the technical capacity and improving health delivery systems at the provincial level, including supporting the Provincial Health Office technical staff, not covered within the REACH program. SC is well-positioned to support the BPHS through CS-19, given the history of successful SC programs in Afghanistan and the technical capacity building and innovation that SC</p>
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	<p>can offer to complement the new health policy. The goal of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan, which will be met through the achievement of the following strategic objective and intermediate results: SO: Improved health practices at household level, and increased use of essential MCH services; IR-1: Increased household-level knowledge of essential MCH practices in Jawzjan province; IR-2: Increased access to essential MCH services in Jawzjan province; IR-3: Increased quality of essential MCH services in Jawzjan Province; and IR-4: Established social network to support key behaviors. These results will be achieved through support to the MOH in Jawzjan in the following key intervention areas: Immunization (20%); Nutrition (15%); Control of Diarrheal Diseases (15%); Pneumonia Case Management (20%); and Maternal and Newborn Care (30%). These interventions will be implemented through the following four major cross-cutting strategies: 1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS; 2. Health behavior change activities through health facility staff, CHWs, TBAs, mullahs, teachers, children, and local radio; 3. SC/MOH engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and 4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of two successful approaches (Community Case Management, and Community Defined Quality.)</p>
Partners:	The MOH in Jawzjan Province and Management Sciences for Health (MSH) through the REACH program
Project Location:	Jawzjan Province, including the Andkhoy Cluster, in Northern Afghanistan.

Grant Funding Information:

USAID Funding:(US \$)	\$1,500,000	PVO match:(US \$)	\$500,000
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Target Beneficiaries:

Type	Number
infants (0-11 months):	24,840
12-23 month old children:	17,610
24-59 month old children:	81,750
0-59 month old children:	124,200
Women 15-49:	155,800
Estimated Number of Births:	111,780

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
5%	95%

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey

Health Facility Assessment

Participatory Rapid Appraisal

Community-based Monitoring Techniques

Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Mass Media

Interpersonal Communication

Peer Communication

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	PVOs (Int'l./US) Local NGO Networked Group	Pharmacists Traditional Healers Private Providers	National MOH Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions:

Immunizations 20 %
** CHW Training
** HF Training
Nutrition 15 %
** IMCI Integration
** CHW Training
** HF Training
*** Hearth
*** Cont. BF up to 24 mos.
*** Maternal Nutrition
Acute Respiratory Infection 20 %
** IMCI Integration
** CHW Training
** HF Training

Control of Diarrheal Diseases 15 %
** IMCI Integration
** CHW Training
** HF Training
Maternal & Newborn Care 30 %
** CHW Training
** HF Training
** HF Training

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	0	0	0.0	0.0
Percentage of infants age 6-9 months receiving breast milk and complementary foods	0	0	0.0	0.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0.0	0.0
Percentage of children age 12-23 months who received a measles vaccine	0	0	0.0	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two	0	0	0.0	0.0

signs of childhood illness that indicate the need for treatment				
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0	0.0
Comments				

TB Indicator			
Indicator	Numerator	Denominator	Estimated Percentage
% of new smear positive cases who were successfully treated	0	0	0.0